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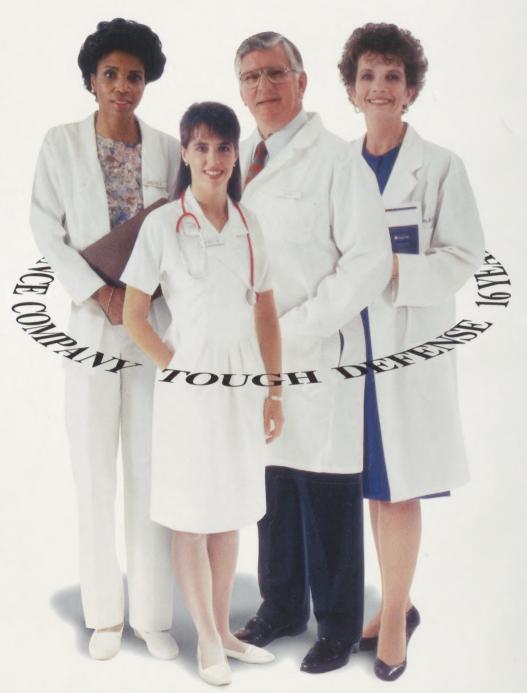
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COVER STORY



SPECIAL REPORT

1996 House of Delegates

The House proposes, it composes and it disposes. This year, there were 106 resolutions and 10 MSMS Board reports for the MSMS delegates to ponder and to act upon. In their action-packed three days, they also installed and elected new officers, honored colleagues and other contributors to the Michigan medical community. In addition, they learned from several instructional sessions on subjects as far-ranging as surfing the Internet and forming a medical service organization. This issue is packed with the highlights, the details and the personalities. Read and enjoy, for a better understanding of what your Michigan State Medical Society is all about.

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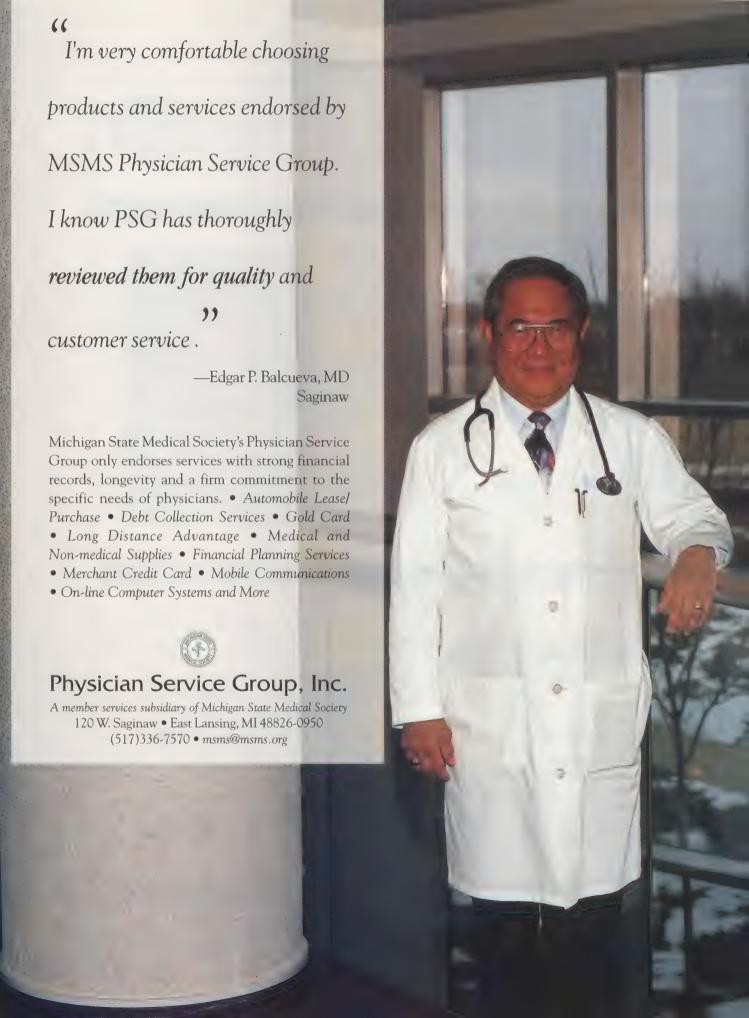
July 1996 Volume 95, Number 7

MSMS Internet E-mail Address: http://www.msms.org/

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the

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Neither the editor nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Michigan Medicine reserves the right to accept or reject advertising copy. Products and services advertised in Michigan Medicine are neither endorsed nor warranteed by MSMS, with the exception of a few.

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the Voice of 12,000 Michigan Physicians

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Report of the 1996 MSMS House of Delegates

The 131st Annual Session of the House of Delegates of the Michigan State Medical Society, convened at 7:30 p.m., Friday, April 26, 1996, at The Ritz Carlton, Dearborn, Speaker Gary D. Maynard, MD, and Vice-Speaker Dorothy M. Kahkonen, MD, presiding.

Invocation

The Speaker called upon The Reverend James E. Greer, II, to give the invocation.

Report of Committee on Credentials and Tellers

Chairman Timothy D. Oliver, MD, reported a quorum seated, the majority of whom were not from any one county.

Report of the Committee on Rules and Order of Business

Chairman Edward C. Bush, MD, reported the actions of the Committee on Rules and Order of Business as follows:

Order of Business: The Committee on Rules and Order of Business approved the Order of Business for the 1996 Annual Session as printed in the Delegates' Handbook.

Late Resolutions: Seven late resolutions were presented to the Committee. The following were accepted for introduction:

Resolution 103-96A - "Preventing and Remedying Lead Poisoning in Michigan" submitted by Domenic R. Federico, MD, Kent County for Douglas A. Mack, MD

Committee Recommendation: That this resolution be accepted.

Resolution 106-96A - "Certificate of Need (CON) Reform" submitted by Timothy B. Aiken, MD, St. Clair County

Committee Recommendation: That this resolution be accepted.

Committee on Constitution and Bylaws

(This standing committee also serves as the Reference Committee on Constitution and Bylaws.)

By Steven E. Newman, MD, Chair

The 1995 House of Delegates adopted the following amendment to the MSMS Constitution and Bylaws on first reading. The amendment was laid over for final reading to the 1996 House of Delegates meeting as prescribed in the Bylaws:

Amend Section 13.70 to read:

"13.70 RULES OF ORDER—When not in conflict with the Constitution or Bylaws of this Society, Robert's Davis Rules of Order shall govern the parliamentary procedure of the House of Delegates."

Since the 1995 House of Delegates meeting the Committee on Constitution and Bylaws has reviewed and edited the final draft copy of the Constitution and Bylaws to ensure accuracy and completeness.

The 1996 Edition of the Constitution and Bylaws will be printed in May 1996 and is available to any member upon request.

Members of the Committee include: Lourdes V. Andaya, MD; R. Paul Clodfelder, MD; Thomas A. Egleston, MD; Robert S. Levine, MD; Dennis A. Smallwood, DO; L. Paul Sonda, III, MD; and Geoffrey A. Wardwell, MD.

1996 Resolutions

Calls to action cover gamut from MSOs to snowmobiles.

Ritchell A. Rinek, MD, for the Ingham County Delegation
Title: Continuing Medical Education
(CME) Fees for Retired Physicians. No Action.

RESOLUTION 2-96A

Brian R. McCardel, MD, for the Ingham County
Delegation

Title: Driving Under the Influence Penalty. No Action.

RESOLUTION 3-96A

Allen F. Turcke, MD, for the Genesee County Delegation

Title: MSMS To Join the National Association of Physicians for the Environment.

Referred to the Board for Study.

RESOLVED: That MSMS join the National Association of Physicians for the Environment.

RESOLUTION 4-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Amendments to the MSMS Hospital Medical Staff Section Bylaws. Adopted as Amended.

RESOLVED: That the MSMS House of Delegates approve changing the name of the MSMS Hospital Medical Staff Section to the MSMS Organized Medical Staff Section.

RESOLUTION 5-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Educational Programs on Professional Contracting. No Action.

RESOLUTION 6-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Physician Membership on Hospital Governing Bodies. Adopted as Amended.

RESOLVED: That MSMS continue to encourage all physicians whether they are Corporate Affiliated Physicians (CAPs) or physicians in the traditional private practice of medicine to participate in their health organizations' governing bodies; and be it further

RESOLVED: That MSMS encourage the Michigan Health and Hospital Association to make known to its member hospitals the importance of governing bodies bringing to membership both CAPs and physicians in the traditional private practice of medicine; and be it further

RESOLVED: That MSMS make available to its members educational sessions pertaining to various aspects of hospital financial and operational management, and that this be provided at a reasonable fee with the appropriate category of CME credit.

RESOLUTION 7-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Specialty Society Status for the American Sleep Disorders Association in the AMA House of Delegates.

Approved.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to approve the American Sleep Disorders Association's request for an AMA House of Delegates specialty society seat.

RESOLUTION 8-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Establishment of a Physician Services Organization (PSO). Substitute Board Action Report (in lieu of Resolutions 8-96A, 74-96A and Board Action Report #1). Adopted. See Board Action Report #10.

(continued on page 9)

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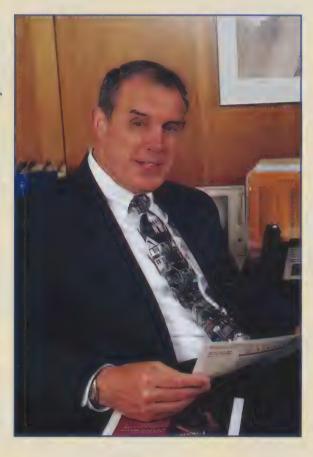
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options available

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major medical

that best suits my

family and my

employees.

—Willard S. Stawski, MD Grand Rapids

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1996 Resolutions (continued)

RESOLUTION 9-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Health Care Service Corporation Commendation. Approved.

RESOLVED: That MSMS commend the Health Care Service Corporation and George R. Gerber, MD, MBA, for their outstanding efforts in achieving this trouble-free Medicare payment process transition.

RESOLUTION 10-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Gag Orders and Hold Harmless Clauses Contained in Managed Care Contracts. Substitute Resolution (in lieu of 10-96A, 18-96A and 36-96A). Adopted.

RESOLVED: That MSMS continue to advise physicians how to identify gag rules (limited patient disclosure) and hold harmless clauses in managed care contracts; and be it further

RESOLVED: That MSMS seek legislation prohibiting Managed Care Organizations (MCOs) from imposing any form of such gag orders, hold harmless clauses, and pejorative treatment arising out of such contractual stipulations; and be it further

RESOLVED: That the Michigan Delegation to the AMA support the AMA's efforts to seek legislation prohibiting managed care organizations from imposing gag orders which would prevent physicians from discussing quality of care issues with their patients; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek legislation making managed care organizations primarily liable for pejorative treatment arising out of gag orders enforced upon their contracted physicians.

RESOLUTION 11-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Designation of Primary Service Providers (PSP) for Medicaid Patients. Approved.

RESOLVED: That MSMS study the problem of the Michigan Department of Community Health Medical Services Administration arbitrarily assigning a physician for patients who fail to designate a Primary Service Provider (PSP) in a timely manner.

RESOLUTION 12-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Uniform Claim Standards. Approved.

RESOLVED: That MSMS continue to seek legislation that would require use of an appropriate universal billing form; and be it further

RESOLVED: That MSMS study the health care problem of multiple post-billing requests by health insurance companies.

RESOLUTION 13-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Arbitrary Discount of Professional Fees for Medical Services by Automobile Insurance Companies. **Approved**.

RESOLVED: That MSMS determine the dimensions, economic impact, and potential solutions to the problem of automobile insurance companies arbitrarily discounting professional fees for medical services to trauma victims of motor vehicle accidents.

RESOLUTION 14-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Pending Status of Payment of Medicaid Approved Procedures. Adopted as Amended.

RESOLVED: That MSMS request an accounting from the Michigan Medicaid Program with specific information of claims pending including an aged analysis and analysis by specialty and report; and be it further

RESOLVED: That MSMS report these findings to its membership via Michigan Medicine.

RESOLUTION 15-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Identification and Review of Standard Exclusions in Health Insurance Contracts. Approved.

RESOLVED: That MSMS determine a method to identify and review exclusions in health insurance contracts and evaluate their impact on the quality of care.

RESOLUTION 16-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Identification of Quality of Care Concerns Caused by the Demands of Third Party Payers and Regulatory Agencies. Adopted as Amended.

RESOLVED: That MSMS identify physicians' quality of care concerns caused by demands of managed care payers and regulatory agencies; and be it further

RESOLVED: That MSMS find a mechanism by which it can act as a clearinghouse for guidelines and benchmarks to assist managed care payers and regulatory agencies in dealing with these quality of care concerns.

RESOLUTION 17-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Advise Physicians Regarding the Importance of Organized Medicine. Adopted as Amended.

RESOLVED: That MSMS continue to educate Michigan physicians regarding the value of membership in their respective county medical societies, MSMS and the AMA; and be it further

RESOLVED: That MSMS continue its assertive membership recruiting efforts by:

Encouraging physician members of a county medical society to become associate members, at nominal dues, in the county society of their residence and/or practice; and

Encouraging county medical societies to accept as associate members, at nominal dues, physicians who are active members of another county medical society where they have residence and/or practice; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to continue to educate physicians regarding the value of membership in their respective county medical societies, state medical societies and the AMA; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to continue its assertive membership recruiting efforts.

RESOLUTION 18-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Hold Harmless Clauses in Managed Care Organizations (MCOs) Contracts.

Substitute Resolution (in lieu of 10-96A, 18-96A and 36-96A). Adopted. See Resolution 10-96A.

RESOLUTION 19-96A

John A. Rupke, MD, for the Hospital Medical Staff Section

Title: Evaluate the MSMS Board of Directors Election Process. Substitute Resolution (in lieu of 19-96A, 64-96A and 81-96A). Adopted.

RESOLVED: That the MSMS Speaker of the House of Delegates and the Chair of the Board of Directors together appoint an ad hoc committee with wide representation from component county medical societies, specialty societies and the MSMS sections; and be it further

RESOLVED: That the ad hoc committee review the governance of MSMS, evaluate the role of county medical societies and whether members are getting value for their dues, and review the distribution of Michigan delegates to the AMA; and be it further

RESOLVED: That the ad hoc committee present a report and recommendations to the 1997 MSMS House of Delegates.

RESOLUTION 20-96A

Peter S. Chang, MD, for the Young Physicians Section

Title: Seat Belt Usage. Adopted as Amended.

RESOLVED: That MSMS endorse the proposed Michigan legislation to achieve the greatest protection of persons through primary enforcement of seat belt use; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to compile available data which study the effect on the human body in automobile accident situations at various speeds and seat belt and/or airbag use, as well as child and infant restraining devices, and these findings be disseminated for professional and public information and education.

RESOLUTION 21-96A

Peter S. Chang, MD, for the Young Physicians Section

Title: Young Physicians Section (YPS) Survey. Adopted.

RESOLVED: That MSMS conduct a new

survey of all young physician members and nonmembers to obtain specific information about their current concerns and what MSMS benefits and services can be developed to further attract young physicians to organized medicine; and be it further

RESOLVED: That MSMS share the results of the Young Physicians Section (YPS) survey with all MSMS committees, members and county medical societies.

RESOLUTION 22-96A

Peter S. Chang, MD, for the Young Physicians Section

Title: Recycling at the MSMS Joint Section Meeting and the MSMS House of Delegates. Approved.

RESOLVED: That recycling bins for paper be made available and prominent at the back of the meeting room for the day of the MSMS Joint Section Meeting and the final day of the MSMS House of Delegates meeting; and be it further

RESOLVED: That the Section Chairs, Speaker of the House, and other appropriate individuals remind the delegates and representatives that they should recycle their papers in the recycling bins at the end of the meetings if they do not intend to keep them.

RESOLUTION 23-96A

Peter S. Chang, MD, for the Young Physicians

Title: MSMSNET and Electronic Communications. Adopted as Amended.

RESOLVED: That MSMS solicit but not require e-mail addresses as part of the application process for society membership, and that these addresses be available for use by the members in a secured form so that cost-efficient messages can be transmitted to the membership and between members on a timely basis.

RESOLUTION 24-96A

Peter S. Chang, MD, for the Young Physicians Section

Title: Development of a Guide to the Internet. Adopted as Amended.

RESOLVED: That MSMS work with MSMS Young Physicians Section, MSMS Resident Physicians Section, and the Committee on Technology in Medicine to develop or customize

and distribute a basic and brief informational guide to explain Internet technology using simple instructions, so that any physician with access to a computer could learn to use these powerful resources; and be it further

RESOLVED: That MSMS distribute the guide to the Internet in both printed and electronic versions to new members when they join MSMS and be made available to current members upon request.

RESOLUTION 25-96A

Peter S. Chang, MD, for the Young Physicians Section

Title: Mentor Program for Young Physicians at the County Medical Society Level. Approved.

RESOLVED: That MSMS work with the Young Physicians Section (YPS) to develop a "peer mentor" program for young physicians at the county medical society level; and be it further

RESOLVED: That MSMS use this program to cultivate young physician involvement in organized medicine.

RESOLUTION 26-96A

Peter S. Chang, MD, for the Young Physicians Section

Title: The Impact of Alcohol and Tobacco Advertisement to Minors. No Action.

RESOLUTION 27-96A

Linda K. Stanley, MD, Berrien County

Title: Restrict Availability of Over-the-Counter Nicotine. Referred to the Board for Study.

RESOLVED: That MSMS seek legislation to restrict the over-the-counter sale of nicotine gum to minors and to control the sale of nicotine gum to adults; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek legislation to restrict the over-the-counter sale of nicotine gum to minors, to control the sale of nicotine gum to adults, and to study the long term addictive effects of non-tobacco nicotine products.

RESOLUTION 28-96A

Donald R. Peven, MD, MI Society of Pathologists Title: Interstate Practice of Medicine. Referred to the Board for Study.

RESOLVED: That MSMS oppose the concept of granting limited licenses allowing non-Michigan physicians to practice medicine across state lines to Michigan; and be it further

RESOLVED: That MSMS seek legislation mandating that primary medical diagnosis and treatment of any patient in Michigan be provided only by or under the direct supervision of a licensed health care professional with a full and unrestricted Michigan medical license.

RESOLUTION 29-96A

Donald R. Peven, MD, MI Society of Pathologists Title: Legislative Database. Substitute Resolution. Adopted.

RESOLVED: That MSMS compile a database of votes cast by the Michigan legislature related to issues on which MSMS has a stated position; and be it further

RESOLVED: That MSMS provide the database to the membership in a timely fashion prior to elections so physicians can determine the degree of support for their elected officials; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to develop a similar database for elected officials at the national level.

RESOLUTION 30-96A

Harvey W. Halberstadt, MD, for the Oakland County Delegation

Specialists Who Are Not Board Title: Certified. No Action.

RESOLUTION 31-96A

Robert S. Levine, MD, for the Oakland County Delegation

Drivers With Suspended Licenses. Title: Referred to the Board for Study.

RESOLVED: That MSMS seek legislation which would allow for the impounding and or confiscation of motor vehicles being operated by individuals with suspended licenses.

RESOLUTION 32-96A

Jaime V. Aragones, MD, for the Oakland County Delegation

Physician Participation in Educational Title: Programs for Total Care Patient Management. No Action.

RESOLUTION 33-96A

Harvey W. Halberstadt, MD, for the Oakland

County Delegation

Title: Disaffiliated Physicians. No Action.

RESOLUTION 34-96A

Harvey W. Halberstadt, MD, for the Oakland County Delegation

Title: Drivers License Suspensions. Approved.

RESOLVED: That MSMS ask the Secretary of State to issue guidelines for the assessment of a driver's competence because of a medical illness, an emotional disorder, medications and/ or alcohol or illicit drug abuse; and be it further

RESOLVED: That MSMS ask the Secretary of State that these guidelines include due process to protect individuals' driving privileges and that persons' health records are not made public.

RESOLUTION 35-96A

Jaime V. Aragones, MD, for the Oakland County Delegation

Title: Drunken Drivers with Suspended Licenses. Referred to the Board for Study.

RESOLVED: That MSMS seek legislation regarding the confiscation of privately owned vehicles used by drivers with suspended licenses while driving under the influence of alcohol.

RESOLUTION 36-96A

Edward M. Cohn, MD, for the Oakland County Delegation

Title: Gag Orders Imposed on Physicians by Managed Care Organizations (MCOs) Substitute Resolution (in lieu of 10-96A, 18-96A and 36-96A). Adopted. See Resolution 10-96A.

RESOLUTION 37-96A

Robert S. Levine, MD, for the Oakland County Delegation

Title: Weakening Handgun and Assault Weapon Regulations. Approved.

RESOLVED: That MSMS oppose any legislation that would weaken the current laws regarding the manufacture, importation and/or ownership of assault weapons and/or handguns.

RESOLUTION 38-96A

Bruce T. Lessien, MD, for the Oakland County Delegation

Title: Financial Disclosure for Health Insurance Companies. Approved.

RESOLVED: That MSMS seek legislation requiring all health insurance companies operating in this state to annually send their subscribers a breakdown of expenses for the previous year; and be it further

RESOLVED: That MSMS seek provisions in this legislation to include in this report the percentage of gross revenues as well as real dollar amounts spent on executive salaries, advertising, promotion and sponsorship of public events as well as the amount of money spent directly to reimburse the subscribers' actual health care

RESOLUTION 39-96A

Hassan Amirikia, MD, for the Wayne County Delegation

Title: Medical Students as Counted Members of MSMS. Referred to the Board for Study.

RESOLVED: That MSMS change its bylaws to include medical students as counted members of MSMS; and be it further

RESOLVED: That MSMS include students who are members of a county medical society in the determination of delegate positions for the MSMS House of Delegates.

RESOLUTION 40-96A

Hassan Amirikia, MD, Wayne County, for Fred W. Fitzpatrick, MD

Title: Immunizations Without Liability Hazard. No Action.

RESOLUTION 41-96A

Hassan Amirikia, MD, Wayne County, for E. Michael Krieg, MD

Title: Examination for State Re-licensure.

Adopted as Amended.

RESOLVED: That MSMS oppose mandatory examination for re-licensure by the State of Michigan except for re-licensure after forfeiture of the original license.

RESOLUTION 42-96A

Hassan Amirikia, MD, Wayne County, for Robert P. Lilly, MD

Title: Support of Cost Control Mechanisms.

Disapproved.

RESOLUTION 43-96A

Hassan Amirikia, MD, Wayne County, for Robert P. Lilly, MD

Title: MSMS Merit Award for Distinguished Service. Substitute Resolution (in lieu of 43-96A, 44-96A and 46-96A). Adopted.

RESOLVED: That MSMS establish and set criteria for a Merit Award for distinguished service by members at the state and county levels of organized medicine, and that this Merit Award be named in honor of the late Charles C. Vincent, MD.

RESOLUTION 44-96A

Hassan Amirikia, MD, Wayne County, for Robert P. Lilly, MD

Title: Gerald H. Mandell, MD, President-fora-Day. Substitute Resolution (in lieu of 43-96A, 44-96A and 46-96A). Adopted. See Resolution 43-96A.

RESOLUTION 45-96A

Hassan Amirikia, MD, Wayne County, for Robert P. Lilly, MD

Title: Identification at MSMS House of Delegates. Adopted as Amended.

RESOLVED: That the MSMS House of Delegates Speakers require that all speakers from the floor at the meeting must identify themselves by name, county, and whether speaking as an individual or representative of a county, specialty society or corporate entity.

RESOLUTION 46-96A

Dorothy M. Kahkonen, MD, for the Wayne County Delegation

Title: Charles C. Vincent, MD, President-fora-Day. Substitute Resolution (in lieu of 43-96A, 44-96A and 46-96A). Adopted. See Resolution 43-96A.

RESOLUTION 47-96A

Martin H. Daitch, MD, for the Wayne County Delegation

Title: Health Maintenance Organizations (HMOs) and Managed Care Advertising/Commercials. **Approved**.

RESOLVED: That MSMS urge Health Maintenance Organizations (HMOs) and managed care groups to cease and desist in suggesting that doctors belonging to their insurance plan represent the best of all physicians.

RESOLUTION 48-96A

Martin H. Daitch, MD, for the Wayne County Delegation

Title: Blue Cross Blue Shield of Michigan (BCBSM) and Medicaid Correspondence. Adopted as Amended.

RESOLVED: That MSMS request that Blue Cross Blue Shield of Michigan (BCBSM), Medicaid and other third party payers use appropriate professional titles in correspondence to physicians in lieu of terms such as "Dear Provider/Dear Vendor."

RESOLUTION 49-96A

Samuel I. Edwin, MD, for the Wayne County Delegation

Title: Drive-thru Deliveries. Approved.

RESOLVED: That MSMS actively support House Bill 5109 which requires Health Maintenance Organizations (HMOs) to cover post delivery, inpatient hospital services for a mother and her newly born child for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section, unless mother and physician agree on an earlier discharge.

RESOLUTION 50-96A

Martin H. Daitch, MD, for the Wayne County Delegation

Title: Illegal Practice of Medicine by Representatives of Third Party Payers. Adopted as Amended.

RESOLVED: That MSMS request physicians to notify MSMS if a physician believes that illegal medical practice is occurring because of decisions made by nonphysician representatives of third party payers; and be it further

RESOLVED: That MSMS request physicians to notify MSMS if physicians believe that illegal practice of medicine is occurring because of decisions being made by a physician not licensed in Michigan; and be it further

RESOLVED: That MSMS explore through legal counsel whether such incidents involving decisions made by nonphysician representatives of third party payers or decisions made by physicians not licensed in Michigan constitute illegal practice of medicine, and identify appropriate remedies as needed.

RESOLUTION 51-96A

Hassan Amirikia, MD, for the Wayne County Delegation

Title: Coverage of Immunization by Third Party Payers. Approved.

RESOLVED: That MSMS call upon all third party payers, especially fee-for-service health plans, to provide coverage of immunizations recommended by national authorities (e.g. Federal Advisory Committee on Immunization Practices, American Academy of Pediatrics); and be it further

RESOLVED: That MSMS work with fee-forservice health plans, large businesses and labor organizations in Michigan to encourage health insurance coverage of recommended immunizations.

RESOLUTION 52-96A

Martin H. Daitch, MD, for the Wayne County Delegation

Title: Medical Expert Witness. No Action.

RESOLUTION 53-96A

Dorothy M. Kahkonen, MD, Wayne County, for W. Peter McCabe, MD

Designation of State and County Title: Medical Society for Retired Physician Membership. Adopted as Amended.

RESOLVED: That MSMS permit a retired physician member of the federation of medicine to designate the county and state medical society where the physician last belonged as the tally and credit site for membership regardless of the physician's retirement address; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to permit a retired physician members of the federation of medicine to designate the county and state medical society where the physician last belonged as the tally and credit site for membership regardless of the physician's retirement address.

RESOLUTION 54-96A

Hassan Amirikia, MD, Wayne County, for Robert P. Lilly, MD

Title: Senior Physicians Section. Disapproved.

RESOLUTION 55-96A

Rudy W. Stefancik, MD, for the Houghton-Keweenaw-Baraga Delegation

Title: Snowmobile Speed Limit Legislation.
Adopted as Amended.

RESOLVED: That MSMS seek legislation which would allow any property damage or personal injury accident attributed to loss of control on a snowmobile trail shall be prima-facia evidence of violation of the basic speed law; and be it further

RESOLVED: That this legislation include a uniform basic speed law requiring snowmobiles not to go faster than trail conditions warrant or the applicable speed limit, whichever is slower, shall also be passed, so as to protect those who maintain local trails while putting the responsibility for operation at a safe speed solely upon the snowmobile driver.

RESOLUTION 56-96A

William H. Woodhams, MD, Kalamazoo County Title: Chemical or Biological Terrorist Attack in the United States. **Approved**.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to identify the main risks of a terrorist chemical or biological attack against the United States; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to inform its members of proper emergency procedures and treatment to be undertaken if such an attack should occur.

RESOLUTION 57-96A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Establish an AMA Sponsored Network for International Medical Graduates (IMGs). Approved.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to approve the concept of networks for International Medical Graduates (IMGs) and establish criteria for network representation for IMGs in the AMA House of Delegates; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to provide adequate staffing and funding for an International Medical Graduate (IMG) Network to adequately function and serve as an advocate for IMG issues and concerns; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to begin at once to assist the IMG Caucus in a transition to an IMG Network.

RESOLUTION 58-96A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Selection of Residents Based on Skill and Qualification. Adopted as Amended.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to reaffirm its present policy that provides for residency selection on the basis of merit, skill and qualification irrespective of the medical school of graduation, and disseminate this policy widely to residency program directors; and be it further

RESOLVED: That the MSMS Board of Directors and the AMA respond quickly and strongly to published or otherwise conveyed policies which discriminate against IMG selection for postgraduate medical training programs; and be it further

RESOLVED: That the MSMS Board of Directors and the AMA develop policies and procedures to monitor the selection of IMGs into postgraduate medical training programs.

RESOLUTION 59-96A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Restrict Access to Firearms for Children.
No Action.

RESOLUTION 60-96A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Support Legislation Restricting Alcohol and Tobacco Advertising. Adopted as Amended.

RESOLVED: That MSMS support legislation at the state and federal levels to ban alcohol advertising on billboards or buildings within the immediate vicinity of schools and hospitals; and be it further

RESOLVED: That MSMS support legislation at the state and federal levels to ban alcohol advertising during family and children television programs.

RESOLUTION 61-96A

Ashok R. Sonnad, MD, Gratiot County
Title: Safeguarding Our Public Roads. No
Action.

RESOLUTION 62-96A

Patrick J. Droste, MD, Kent County

Title: Laser Surgery by Doctors of Medicine and Osteopathy. Referred to the Board for Study.

RESOLVED: That MSMS actively support efforts and legislation that promote laser surgery on humans to be performed exclusively by licensed doctors of allopathic medicine, osteopathy, podiatry and dentistry with proper training.

RESOLUTION 63-96A

Joseph A. Arena, Jr., MD, for the Oakland County Delegation

Title: Health Maintenance Organization (HMO) Contracts. **Disapproved**.

RESOLUTION 64-96A

Robert S. Levine, MD, for the Oakland County Delegation

Title: Cost Effective Consolidation and Reorganization. Substitute Resolution (in lieu of 19-96A, 64-96A and 81-96A). Adopted as Amended. See Resolution 19-96A.

RESOLUTION 65-96A

Domenic R. Federico, MD, for the Kent County Delegation

Title: Determination of Disability and Impairment. Approved.

RESOLVED: That MSMS encourage the appropriate agencies to adopt the AMA guidelines as standards for the determination of disability and impairment.

RESOLUTION 66-96A

Domenic R. Federico, MD, for the Kent County
Delegation

Title: Domestic Violence. No Action.

RESOLUTION 67-96A

Domenic R. Federico, MD, for the Kent County Delegation

Title: Physical and Mental Abuse. No Action.

RESOLUTION 68-96A

Domenic R. Federico, MD, for the Kent County Delegation

Title: Alternative to Physician Assisted Suicide. Adopted as Amended.

RESOLVED: That MSMS form a task force to study support and treatment options for

chronically ill individuals who have considered assisted suicide.

RESOLUTION 69-96A

Domenic R. Federico, MD, for the Kent County Delegation

Title: Stability of Health Insurance Coverage and the Doctor/Patient Relationship.

Referred to the Board for Study.

RESOLVED: That MSMS work with the health insurance industry to mandate three year contracts for health insurance policies; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to work with the health insurance industry to mandate three year contracts for health insurance policies.

RESOLUTION 70-96A

Domenic R. Federico, MD, for the Kent County Delegation

Title: Patient Satisfaction Surveys of Health Maintenance Organization (HMO) Mandated Laboratory and Radiological Services. Adopted as Amended.

RESOLVED: That MSMS work with the Michigan Department of Community Health to develop standardized patient satisfaction surveys for managed care programs to evaluate managed care, medical and/or clinical care, laboratory and radiology programs.

RESOLUTION 71-96A

Domenic R. Federico, MD, for the Kent County Delegation

Title: Motorcycle Helmet Laws. Adopted as Amended.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to reaffirm current policy encouraging all state legislatures to make motorcycle helmet use mandatory in all fifty states.

RESOLUTION 72-96A

Domenic R. Federico, MD, for the Kent County Delegation

Title: Snowmobile and Boating DUI (Driving Under the Influence). No Action.

RESOLUTION 73-96A

Domenic R. Federico, MD, for the Kent County Delegation

Continued on page 19



Calling The Shots

Michigan State Medical Society Peer Education Project on Immunization



Immunizing Michigan's Children:

We must all recommit ourselves to this task

Dear Colleagues:

The state of Michigan, according to a 1995 Centers for Disease Control study, has the lowest number (63 percent) of fully immunized 0-to-2-year-olds in the country. This alarming statistic led the Michigan State Medical Society (MSMS) and the Michigan Department of Community Health (MDCH) to form an alliance to improve the immunization levels of Michigan's

children. Review of current medical literature and practice experience allows us to draw several conclusions that can be translated into medical practice.

Social, cultural and economic barriers exist for some children. However, approximately half of the children whose immunizations are not up-to-date have been to their primary care provider at least once when an immunization could have been given. Many of these missed opportunities occurred because nurses and doctors had inaccurate ideas about contraindications to immunization. Other children were missed because physicians and office staff failed to recognize an opportunity to immunize.

Lack of parental understanding is not necessarily to blame; physicians' knowledge of correct policies and procedures can overcome this

obstacle and is correlated with high immunization rates.

Most physicians overestimate their immunization rates.

Auditing of medical records provides for a good overview

of individual immunization practices.

The MSMS Peer Education Project on Immunizations has identified several ways that active physicians can motivate themselves and their staffs in an easy, quick and economical manner. These methods include improving knowledge about immunization policy and procedures, checking immunization status at ev-

ery visit and auditing their own immunization rates.

The MSMS Peer Education Project on Immunization has practical tools and information that physicians can easily incorporate into their practices in order to improve immunization rates. (For details, see back page.)

In addition to physicians' efforts, we also need the attention and interest of our political leaders, local health departments, employers, the health insurance industry and community leaders. But first, we must take care of our responsibility to our patients, as health care providers, and make sure that every medical encounter is an opportunity to immunize.

Thank you for all of your efforts to care for and protect the children of Michigan.

"Physicians"
knowledge of
correct policies
and procedures...
is correlated with
high immunization
rates."



Howard Weinblatt, MD

Howal Weullest in

Chair, Michigan State Medical Society Task Force on Immunization

Ann Arbor

Mythinformation Answered:

The many myths surrounding childhood immunizations

Myth: Don't give immunizations if a child has an upper respiratory infection.

Fact: Immunizations may be given if patient has a mild acute illness (e.g. upper respiratory illness) with a low grade fever. Contraindicated in moderate or serious acute illness with or without fever.

Myth: If a child is on antibiotics, wait until course is completed before giving immunizations.

Fact: Immunizations may be given while on antibiotics.

Myth: If a dose is missed, the series must be restarted.

Fact: Even if dose is missed, the series never needs to be restarted. Give the next dose due and continue the series as indicated.

Myth: Preterm infants should be given immunizations according to gestational age.

Fact: Preterm infants should be given immunizations according to chronological age (exception: hepatitis B not given if infant is less than 2kg if mom is HbsAg-negative).

Myth: Don't give immunizations to a child whose mother is pregnant or breastfeeding.

Fact: May give immunizations if mother or household contact is pregnant or breastfeeding. However diaper precautions exist when a live virus vaccine is used.

Myth: Don't give immunizations if allergic to feathers or duck meat.

Fact: May give immunizations if patient has feather or duck meat allergy. Anaphylactic reaction to eggs is a contraindication in some vaccines; skin testing of immunizations is recommended.

Myth: Don't give immunizations if there is a family history of seizures or SIDS.

Fact: May give immunizations regardless of family history.

Consider giving acetaminophen before DTP or DTaP and every four hours thereafter for 24 hours to children who have a personal or family history of convulsions.

Myth: Don't give immunizations if the child is allergic to antibiotics.

Fact: Anaphylactic allergy to neomycin or streptomycin are the only antibiotic allergy contraindications.

Myth: Don't give immunizations if the previous dose caused redness, swelling or fever.

Fact: May give immunizations if previous vaccination only caused local reaction or fever of less than 105F. If a previous reaction occurred with DTP/DTaP consider giving acetaminophen before and every 4 hours thereafter for 24 hours to children who have a personal or a family history of convulsions. Anaphylactic (life-threatening) reactions from any other vaccine contraindicates vaccination only with vaccine to which reaction occurred.

Myth: Don't vaccinate a child who has a family member with a serious reaction or allergy to that vaccine.

Fact: May give immunizations regardless of family history.

Myth: Don't give a child an immunization if recently exposed to the disease.

Fact: May give regardless of exposure to infectious disease. However, the vaccine may not protect the child against the disease if the disease has already been contracted.

Myth: Reduce the DTP dose in half if child or family member had a reaction to a previous immunization.

Fact: Never divide or reduce doses. May cause inadequate antibody response, does not decrease the incidence of adverse reactions, and may actually sensitize the patient and increase the chances of adverse reactions in subsequent doses.

Myth: No more than two vaccines should be given at a time.

Fact: Any number of vaccines may be given at the same time, but must be in separate syringes and at separate sites. (The only exception is yellow fever and cholera vaccines together). If live virus vaccines are not administered on the same day they should be separated by four weeks, except OPV which may be administered at any time before or after any other vaccine.



This information is based on the recommendations of the Advisory Committee on Immunizations Practices (ACIP) and those of the Committee on Infectious Diseases (Red Book Committee) of the American Academy of Pediatrics (AAP). Sometimes these recommendations vary from those contained in the manufacturer's package inserts. For more detailed information, providers should consult the published recommendations of the ACIP, the AAP, the American Academy of Family Physicians (AAFP) and the manufacturer's package inserts.

Recommended Immunization Schedule



	Meconiii	icriaca	IIIIIIIIII	IZCICIOI :	Scriede		Leauership for Physi	sicians, Aavocacy for Patient		a la
	Birth	2 Months	4 Months	6 Months	6-18 Months	12-15 Months	12-18 Months	4-6 Years	6-16 Years	
DTP Diptheria, Tetanus, Pertussis										This schedule was
OPV Polio										developed by the National Immuniza tion Program, Centers for Disease Control and Prever tion, using informa tion derived from the Standards for
Hib Haemophilus Influenzae Type B										Pediatric Immunization Practices, recommendations of the Advisory Committee on Immunization Practices (ACIP), and those of the
HEP B* Hepatitis B										Committee on Infectious Diseases (Red Book Committee) of the American Academy of Pediatrics (AAP). Some of these recommendations
MMR Measles, Mumps, Rubella										may differ from those stated in manufacturers' package inserts. For more details, consult the published recommen-
Td Tetanus, Diptheria										dations of the ACIF the AAP, and the American Academy of Family Physician (AAFP), and manu- facturers' package inserts.
Varicella Chicken Pox										

*Alternative schedules are possible

The children in

boxes indicate

recommended

immunization

schedule.

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The Realities of Varicella and its Vaccine

Ruth Ann Dunn, MD, Professor Department of Pediatrics and Human Development Michigan State University

Is varicella worth preventing?

Yes. Each year there are an estimated 4 million cases of varicella. Though usually a benign disease, there may be complications such as pneumonia, encephalitis, post-varicella cerebellitis, and secondary bacterial skin infections. Roughly 9,000 hospitalizations and 100 deaths per year are attributed to varicella and its complications, mostly in immunocompetent individuals.

The vaccine was developed to help prevent the misery and disruption of varicella, as well as the most serious threats the disease and its complications may present. The varicella vaccine is safe, and effective and is also cost effective. For every \$1 spent on the vaccine, \$5 will be saved in health care costs and wages.

Will the vaccine give sufficient protection?

Experience shows the varicella vaccine to be 95 percent effective for mild disease and 100 percent effective for severe disease.

present that immunity is persistent. Nevertheless, the need for a booster dose will continue to be evaluated in post-licensure studies. In the worst case scenario, if a vaccinee experiences breakthrough disease as an adult the disease is always mild, certainly less serious than if a wild-type virus were contracted by an unvaccinated individual.

Is there a risk that vaccine virus will be transmitted to a susceptible contact?

There is a rare risk that the vaccine virus will be transmitted.

This potential risk should not prohibit healthy children from receiving the vaccine. Current studies indicate that this potential risk only exists when there is a rash present. Those children who develop a rash within one month of immunization should avoid close con-

immunocompromised people for 6-8 weeks.

When children are vaccinated, will long term immunity persist so that they will not become susceptible as adults?

Vaccinees receive a boost in immunity when exposed to wild-type virus, especially now while wild-type disease is still widespread. However, as more of the population is vaccinated and presumably there is a reduction of exposure to wild-type virus, natural boosting may be less prevalent. At that point, there may be a need for a booster to help ensure long term immunity. However, 20 years of experience with varicella

vaccine in Japan indicates at

"The involvement of the Michigan State Medical Society and MAOPS in Michigan's immunization initiatives has been a valuable contribution in getting Michigan moving to improve rates amont two-year-olds. I look forward to our continued collaboration in protecting young children from the risks of these diseases in the particularly vulnerable years of early child-

James K. Haveman Director Michigan Department of Community Health

hood."

Shot Stops Top 10 Reasons Why Immunizations May Not Be Up-To-Date

- 10 It's expensive.
 - 9 It hurts.
 - 8 My child is not a human pincushion.
 - 7 I don't have time to go to the doctors office.
 - 6 Health department hours are inconvenient.
 - 5 My insurance doesn't cover it.
 - 4 My doctor hasn't mentioned it.
 - 3 Of course my kids are up to date.
 - 2 My child is already sick.
 - 1 Those diseases don't exist anymore.



Top 10 Responses to the "Top 10 Reasons Why Immunizations May Not Be Up-To-Date"

- 10 Free vaccines are available for eligible children. In addition, medical, pharmacy and hospital costs resulting from complications may be very expensive.
- 9 The discomfort is very temporary, in the long run, diseases would be worse.
- 8 Suffering from the diseases would be much worse than a few pin pricks.
- 7 It only takes a few minutes for an office visit, but days to weeks to recover from an infectious disease which may also include lost school days and parental work loss.
- 6 Your physicians office may have access to free or low cost vaccines for eligible children.
- 5 Your child may be eligible for free or low cost vaccines.
- 4 Though its a physicians' responsibility to know health status of a patient. It's also a parents' responsibility to ensure that the vaccinations are current.
- 3 You may think so, but check regularly with your doctor's office and a reliable vaccine schedule to ensure your childs' vaccines are current. DO NOT ASSUME. As new vaccines are developed, there may be new opportunities and immunization scheduling to help further protect your child.
- 2 Many mild illnesses and injuries do not interfere with timely immunization.
- 1 If there is a vaccine, then there is a disease in need of prevention.

Itchin' to Talk Chicken Pox

Do your patients itch just to talk to you? Chickenpox is a common childhood illness that should be prevented. In addition to potentially serious complications, it is also a cause for kids' long absences from school and daycare and parents' absences from work.

Children or adults who develop this disease tend to be miserable for at least a week. Adolescents and adults are more likely to develop complications from the disease. Chickenpox is contagious from

a day or two prior to the rash developing until the "pox" are completely scarred over. Irritability, fever, loss of appetite and headache also may accompany the spots.

An end may potentially be near. Merck & Co., Inc., Vaccine Department has introduced the varicella vaccine. This vaccine should be recommended for routine immunization for appropriate patients. Clinical trials of the varicella vaccine showed no breakthrough cases of chickenpox in 80 percent of the exposed children. Twenty percent of the exposures resulted in mild cases.

In addition to routine infant immunization the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP) and Advisory Committee on Immunization Practices (ACIP) recommend this vaccine for all susceptible catch-up cohorts. Well baby and

back-to-school exams are ideal opportunities to check overall immunization histories and

vaccinate against chickenpox. A second dose of vaccine is needed four to eight weeks after a primary dose for adolescents and adults.

If you have any questions regarding the chickenpox vaccine, please contact the MSMS immunization project

at 517-336-5707.



Nancy Fasano, acting chief of the immunization section at MDCH, at 517-335-9423, can arrange a free, computerized audit of your records to obtain specific data on your immunization levels. A follow-up informational session will provide you with suggestions tailored to your office situation.

The Project provides a speakers bureau comprised of CME accredited physicians trained in the area of immunization, available to any interested physician, medical staff or hospital. The Project recommends that individual practices, hospital de-

partments and county medical societies further edu-

Eliminate Spots!

With Immunizations.

Michigan State Medical Society

cate themselves on vaccines. Practical, office-tested reminder techniques, individualized for your unique practice, can be demonstrated. Informational materials for patient and staff education also are available and can be ordered through MSMS. Contact Kathy Holcomb, Coordinator of the Project, at 517-336-5707 or e-mail kholcomb@msms.org, or Jean Capriotti, Project Assistant, at 517-336-5706 or e-mail jcapriotti@msms.org, to schedule a speaker, or to sign up as a speaker yourself.



Reminder postcards available



Michigan State Medical Society

Leadership for Physicians, Advocacy for Patients 517-337-1351 FAX: 517-337-2490 e-mail: msms@msms.org

http://www.msms.org/

chickenpox. now you see them...

For many patients...

now you won't.

Vaccinate all appropriate susceptibles during back-to-school and other routine checkups.

It's time to help protect susceptibles with



The First Vaccine Against Chickenpox Available In The U.S.

VARIVAX is indicated for vaccination against varicella in individuals 12 months of age and older.

VARIVAX is contraindicated in individuals with a history of hypersensitivity or an anaphylactoid reaction to any component of the vaccine including gelatin or neomycin, or with any immunodeficient condition or receiving immunosuppressive therapy. VARIVAX should not be administered during pregnancy. Pregnancy should be avoided for three months following vaccination.

For details concerning contraindications, warnings, precautions, adverse effects, and dosage and administration, please see the Brief Summary on the next page.

MERCK

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BRIEF SUMMARY

Please read the full Prescribing Information for complete details

INDICATIONS AND USAGE

VARIVAX® [Varicella Virus Vaccine Live (Oka/Merck)] is indicated for vaccination against varicella in individuals 12 months of age and older.

Revaccination

The duration of protection of VARIVAX is unknown at present and the need for booster doses is not defined. However, a boost in antibody levels has been observed in vaccinees following exposure to natural varicella as well as following a booster dose of VARIVAX administered four to six years post vaccination.

In a highly vaccinated population, immunity for some individuals may wane due to lack of exposure to natural varicella as a result of shifting epidemiology. Post-marketing surveillance studies are ongoing to evaluate the need and timing for booster vaccination.

Vaccination with VARIVAX may not result in protection of all healthy, susceptible children, adolescents, and adults (see CLINICAL PHARMACOLOGY section of the full Prescribing Information).

CONTRAINDICATIONS

A history of hypersensitivity to any component of the vaccine, including gelatin.

A history of anaphylactoid reaction to neomycin (each dose of reconstituted vaccine contains trace quantities of

Individuals with blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems.

Individuals receiving immunosuppressive therapy. Individuals who are on immunosuppressant drugs are more susceptible to infections than healthy individuals. Vaccination with live attenuated varicella vaccine can result in a more extensive vaccine-associated rash or disseminated disease in individuals on immunosuppressant doses of corticosteroids.

Individuals with primary and acquired immunodeficiency states, including those who are immunosuppressed in association with AIDS or other clinical manifestations of infection with human immunodeficiency virus; cellular immune deficiencies; and hypogammaglobulinemic and dysgammaglobulinemic states.

A family history of congenital or hereditary immunodeficiency, unless the immune competence of the potential vaccine recipient is demonstrated.

Active untreated tuberculosis.

Any febrile respiratory illness or other active febrile

Pregnancy: the possible effects of the vaccine on fetal development are unknown at this time. However, natural varicella is known to sometimes cause fetal harm. If vaccination of postpubertal females is undertaken, pregnancy should be avoided for 3 months following vaccination (see PRECAUTIONS, Pregnancy).

Children and adolescents with acute lymphoblastic leukemia (ALL) in remission can receive the vaccine under an investigational protocol. More information is available by contacting the VARIVAX coordinating center, Bio-Pharm Clinical Services, Inc., 4 Valley Square, Blue Bell, PA 19422, (610) 283-0897.

PRECAUTIONS

General

Adequate treatment provisions, including epinephrine injection (1:1000), should be available for immediate use should an anaphylactoid reaction occur.

The duration of protection from varicella infection after vaccination with VARIVAX is unknown.

It is not known whether VARIVAX given immediately after exposure to natural varicella virus will prevent illness

Vaccination should be deferred for at least 5 months following blood or plasma transfusions, or administration of immune globulin or varicella zoster immune globulin (VZIG). Following administration of VARIVAX, any immune globulin, including VZIG, should not be given for 2 months thereafter unless its use outweighs the benefits of vaccination.

Vaccine recipients should avoid use of salicylates for 6 weeks after vaccination with VARIVAX as Reye's syndrome has been reported following the use of salicylates during natural varicella infection.

The safety and efficacy of VARIVAX have not been established in children and young adults who are known

to be infected with human immunodeficiency viruses but who do not have overt clinical manifestations of immunosuppression.

Care should be taken by the healthcare provider for safe and effective use of VARIVAX.

The healthcare provider should question the patient, parent, or guardian about reactions to a previous dose of VARIVAX or a similar product.

The healthcare provider should obtain the previous immunization history of the vaccinee.

VARIVAX should not be injected into a blood vessel.

Vaccination should be deferred in patients with a family history of congenital or hereditary immunodeficiency until the patient's own immune system has been evaluated.

A separate sterile needle and syringe should be used for administration of each dose of VARIVAX to prevent transfer of infectious diseases

Needles should be disposed of properly and should not be recapped.

Transmission

Post-marketing experience suggests that transmission of vaccine virus may occur rarely between healthy vaccinees who develop a varicella-like rash and healthy susceptible contacts. Transmission of vaccine virus from vaccinees without a varicella-like rash has been reported but has not been confirmed.

Therefore, vaccine recipients should attempt to avoid, whenever possible, close association with susceptible high-risk individuals for up to six weeks. In circumstances where contact with high-risk individuals is unavoidable, the potential risk of transmission of vaccine virus should be weighed against the risk of acquiring and transmitting natural varicella virus. Susceptible high-risk individuals include:

- · immunocompromised individuals
- · pregnant women without documented history of chickenpox or laboratory evidence of prior infection
- · newborn infants of mothers without documented history of chickenpox or laboratory evidence of prior infection

Information for Patients

The healthcare provider should inform the patient, parent, or guardian of the benefits and risks of vaccination. Patients, parents, or guardians should be instructed to report any adverse reactions to their healthcare provider.

Pregnancy should be avoided for 3 months following vaccination.

Drug Interactions

See PRECAUTIONS, General, regarding the administration of immune globulins, salicylates, and transfusions. Use with Other Vaccines

Results from clinical studies indicate that VARIVAX can be administered concomitantly with M-M-R°II (Measles, Mumps, and Rubella Virus Vaccine Live).

Limited data from an experimental product containing varicella vaccine suggest that VARIVAX can be administered concomitantly with DTaP (diphtheria, tetanus, acellular pertussis) and PedvaxHIB® [Haemophilus b Conjugate Vaccine (Meningococcal Protein Conjugate)] using separate sites and syringes (see CLINICAL PHARMACOLOGY, Studies With Other Vaccines in the full Prescribing Information). However, there are no data relating to simultaneous administration of VARIVAX with DTP or OPV.

Carcinogenesis, Mutagenesis, Impairment of Fertility VARIVAX has not been evaluated for its carcinogenic or mutagenic potential, or its potential to impair fertility. Pregnancy

Pregnancy Category C: Animal reproduction studies have not been conducted with VARIVAX. It is also not known whether VARIVAX can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Therefore, VARIVAX should not be administered to pregnant females; furthermore, pregnancy should be avoided for 3 months following vaccination (see CONTRAINDICATIONS).

Nursing Mothers

It is not known whether varicella vaccine virus is secreted in human milk. Therefore, because some viruses are secreted in human milk, caution should be exercised if VARIVAX is administered to a nursing woman.

Pediatric Use

No clinical data are available on safety or efficacy of VARIVAX in children less than one year of age, and administration to infants under 12 months of age is not recommended.

ADVERSE REACTIONS

In clinical trials, VARIVAX was administered to 11,102 healthy children, adolescents, and adults. VARIVAX was generally well tolerated.

In children, adolescents, and adults followed for up to 42 days, the adverse effects most frequently reported were as follows: fever (≥102°F [39°C] oral in children and ≥100°F [37.7°C] oral in adolescents and adults); injection site complaints (pain/soreness, swellings, erythema, rash, pruritus, hematoma, induration, stiffness); and varicella-like rash (injection site and generalized).

In children, adolescents, and adults, adverse experiences reported at ≥1% frequency included, without regard to causality, upper respiratory illness, cough, irritability/ nervousness, fatigue, disturbed sleep, diarrhea, loss of appetite, vomiting, otitis, diaper rash/contact rash, headache, teething, malaise, abdominal pain, other rash, nausea, eye complaints, chills, lymphadenopathy, myalgia, stiff neck, arthralgia, lower respiratory illness, allergic reaction (including allergic rash, hives), constipation, itching, heat rash/prickly heat, eczema/dry skin, dermatitis, and cold/canker sore. In children, pneumonitis (<1%) and febrile seizures (<0.1%) have been reported rarely; a causal relationship has not been established.

As with any vaccine, there is the possibility that broad use of the vaccine could reveal adverse reactions not observed in clinical trials.

The following additional adverse reactions have been reported since the vaccine has been marketed:

Body as a Whole

Anaphylaxis. Nervous/Psychiatric

Encephalitis; ataxia.

Respiratory

Pharyngitis.

Herpes zoster; erythema multiforme.

DOSAGE AND ADMINISTRATION

FOR SUBCUTANEOUS ADMINISTRATION

Do not inject intravenously.

Children 12 months to 12 years of age should receive a single 0.5 mL dose administered subcutaneously. Adolescents and adults 13 years of age and older should receive a 0.5 ml. dose administered subcutaneously at elected date and a second 0.5 mL dose 4 to 8 weeks later.

VARIVAX SHOULD BE STORED FROZEN at an average temperature of -15°C (+5°F) or colder until it is reconstituted for injection (see HOW SUPPLIED, Storage). Any freezer (e.g. chest, frost-free) that reliably maintains an average temperature of -15°C and has a separate sealed freezer door is acceptable for storing VARIVAX. The diluent should be stored separately at room temperature or in the refrigerator. IT IS RECOMMENDED THAT THE VACCINE BE ADMINISTERED IMMEDIATELY AFTER RECONSTITUTION, TO MINIMIZE LOSS OF POTENCY. DISCARD IF RECONSTITUTED VACCINE IS NOT USED WITHIN 30 MINUTES

Do not freeze reconstituted vaccine.

Do not give immune globulin including Varicella Zoster Immune Globulin concurrently with VARIVAX (see also PRECAUTIONS)

HOW SUPPLIED

Storage

During shipment, to ensure that there is no loss of potency, the vaccine must be maintained at a temperature of -20°C (-4°F) or colder.

Before reconstitution, store the lyophilized vaccine in a freezer at an average temperature of -15°C (+5°F) or colder. Any freezer (e.g. chest, frost-free) that reliably maintains an average temperature of -15°C and has a separate sealed freezer door is acceptable for storing VARIVAX.

VARIVAX may be stored at refrigerator temperature (2-8°C, 36-46°F) for up to 72 continuous hours prior to reconstitution. Vaccine stored at 2-8°C which is not used within 72 hours of removal from -15°C storage should be discarded.

VARIVAX°

VARICELLA VIRUS VACCINE LIVE (Oka/Merck)]



1996 Resolutions (continued)

Title: Workers Compensation Current Procedural Terminology (CPT) Codes and Reimbursement. Adopted as Amended.

RESOLVED: That MSMS continue to support the utilization of Current Procedural Terminology (CPT) by the Workers Compensation program; and be it further

RESOLVED: That MSMS ask the Workers Compensation Advisory Committee to study whether the fee schedule should be adjusted to reflect the extensive correspondence cost, documentation requirements and physician services that are unique to the workers compensation system.

RESOLUTION 74-96A

Robert C. Packer, MD, and Frederick B. Brown, MD, for the Muskegon County Delegation

Title: Statewide Physician Owned and Directed Health Maintenance Organization (HMO) in Michigan. Substitute Board Action Report (in lieu of Resolutions 8-96A, 74-96A and Board Action Report #1). Adopted. See Board Action Report #10.

RESOLUTION 75-96A

Dorothy M. Kahkonen, MD, Wayne County, for W. Peter McCabe, MD

Title: Use of Appropriate Titles. Disapproved.

RESOLUTION 76-96A

Susan H. Adelman, MD, for the Wayne County Delegation

Title: Coverage for Today's Uninsured.

Adopted as Amended.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to study carefully the demographic characteristics of the uninsured and underinsured; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to propose a rational set of recommendations for providing the uninsured and underinsured with health care coverage.

RESOLUTION 77-96A

Samuel D. Indenbaum, MD, for the Wayne County Delegation

Title: Incentive Pay Detrimental to Physician/ Patient Relationship. **Disapproved**.

RESOLUTION 78-96A

Samuel D. Indenbaum, MD, for the Wayne County Delegation

Title: Medical Liability Tax. Disapproved.

RESOLUTION 79-96A

Michael A. Dorman, MD, MI Dermatology Society

Title: Direct Access to Specialty Care. No Action.

RESOLUTION 80-96A

Michael A. Dorman, MD, MI Dermatology Society for David A. Altman, MD

Title: Direct Access to Dermatologic Care. No Action.

RESOLUTION 81-96A

William H. McNamara, MD, North Central Counties

Title: Distribution of American Medical Association (AMA) Delegates. Substitute Resolution (in lieu of 19-96A, 64-96A and 81-96A). Adopted as Amended. See Resolution 19-96A.

RESOLUTION 82-96A

Louis R. Zako, MD, for the Northern Michigan Delegation

Title: Strategic Planning Task Force. Adopted as Amended.

RESOLVED: That the MSMS Board of Directors create a Forward Planning Standing Committee to advise the Board and the officers on an ongoing basis to position MSMS in a proactive mode in the face of rapid changes; and be it further

RESOLVED: That the Forward Planning Standing Committee be broadly constituted to include representation from the Board and current officers, past officers, resident physicians and medical students, young physicians, international medical graduates and county medical societies.

RESOLUTION 83-96A

Allan L. Olson, DO, Marquette County Title: Single Payer Health Plan. **Disapproved**.

RESOLUTION 84-96A

Harvey W. Halberstadt, MD, Oakland County Title: Brand Drugs vs. Generic Drugs. Disapproved.



Reference Committee D took testimony on a resolution dealing with the establishment of a management services organization (MSO). From left to right, pictured are Edward M. Cohn, MD (Oakland County), Edwin H. Gullekson, MD (Genessee County), William H. McNamara, MD (North Central Counties), and Kathleen J. Yost, MD (Kent County).

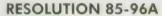


Among delegates rising to provide insight and to challenge the intent of the resolutions were Wendy Larson, MD, chair, MSMS Resident Physicians Section (pictured on the left), and Jaime Aragones, MD, delegate from Oakland County (pictured on the right).





A new MSMS House of Delegates Women Physicians Caucus held its historic first meeting just prior to the opening of the House. The group was chaired by Janice Werbinski, MD, delegate from Kalamazoo County.



Jeffrey C. Custer, MD, Branch County

Title: Support Senate Bill 1028 to Prohibit Insurance Companies From Using the

Pre-Existing Clause. No Action.

RESOLUTION 86-96A

Harvey W. Halbertstadt, MD, Oakland County Title: Parity for Mental Illness. Adopted as Amended.

RESOLVED: That MSMS support legislation that covers the treatment of mental illness to the same limits applied to the treatment of all other non-psychiatric diagnoses; and be it further

RESOLVED: That MSMS support legislation that gives to the treatment of mental illnesses the same scope and duration of coverage, and be subjected to the same reviews, severity, standards and effectiveness requirements as treatment for other medical illnesses; for example, heart disease, cancer and diabetes.

RESOLUTION 87-96A

Harvey W. Halberstadt, MD, Oakland County
Title: Care for Children and Adolescents with
Emotional Disorders. Approved.



The MSMS International Medical Graduates caucus held heated and productive discussions of Michigan residency policies. They were led by Kenneth Jordan, MD, Flint, MSMS IMG Section chair (left), and Busharat Ahmad, MD, Monroe, member, AMA Council on Long Range Planning and Development.

RESOLVED: That the MSMS Board of Directors study the problem of the care and treatment of children and adolescents with emotional disorders, give recommendations for remedy, and propose legislation or changes in public policy.

RESOLUTION 88-96A

Robert L. Bree, MD, for the Washtenaw County Delegation

Title: Prostate Cancer Control Plan for Michigan. Referred to the Board for Study.

RESOLVED: That MSMS endorse the goals of the Michigan Cancer Consortium and help support the professional education component of the Prostate Cancer Control Plan for Michigan thereby informing the physicians of Michigan of the findings and implications of the 1995 Michigan Prostate Consensus Conference on prostate cancer.

RESOLUTION 89-96A

Domenic R. Federico, MD, Kent County, for Douglas A. Mack, MD

Title: Prohibition of Ultimate Fighting (Barbaric and Blood Sports). Adopted as Amended.

RESOLVED: That MSMS oppose ultimate fighting (barbaric and blood sports) competitions in the State of Michigan; and be it further

RESOLVED: That MSMS seek legislation to prohibit ultimate fighting (barbaric and blood sports), and ban its transmission via electronic media.

RESOLUTION 90-96A

Deborah W. Sims, MD, Wayne County

Title: Interruption of Chronic Care Received by Paroled Prison Inmates. **Disapproved**.

RESOLUTION 91-96A

Allen F. Turcke, MD, for the Genesee County Delegation

Title: Create Identical Health Care Billing Form. Approved.

RESOLVED: That MSMS seek legislation mandating that all health insurance companies and managed health care companies in Michigan use an identical billing form.

RESOLUTION 92-96A

Allen F. Turkce, MD, for the Genesee County Delegation

Title: Proposed Changes in the Omnibus Budget Reconciliation Act (OBRA), Health Care Financing Administration (HCFA) Regulations and Michigan Department of Community Health (MDCH) Rules Requiring Therapeutic Interventions for Nursing Home Patients. Adopted as Amended.

RESOLVED: That MSMS recommend to the Michigan Department of Consumer and Industry Services that regulations regarding therapeutic interventions for nursing home patients be rewritten to accommodate patient and family choice for treatment of an individual on a case by case basis.

RESOLUTION 93-96A

Allen F. Turcke, MD, for the Genesee County Delegation

Title: Pursue Changes in Michigan Public Health Code Regarding No-Codes. No Action.

RESOLUTION 94-96A

Allen F. Turcke, MD, for the Genesee County Delegation Title: Consistency in Drug Formularies.

Disapproved.

RESOLUTION 95-96A

Allen F. Turcke, MD, for the Genesee County Delegation

Title: Standardize Insurance for Physician Participation Rules. Adopted as Amended.

RESOLVED: That MSMS seek legislation which would require all managed health care companies and health insurance companies to have identical rules for physician credentialling and privileges by insurance type.

RESOLUTION 96-96A

Mark C. Komorowski, MD, Bay County

Title: Discrimination by Health Insurance Carriers Against Breast Reconstruction. Adopted as Amended.

RESOLVED: That MSMS work with health insurance carriers to support the right for all women to have access to breast reconstruction after breast cancer surgery if they desire it, and that access should be available regardless of timing in relationship to the onset of the deformity or absence of their breast; and be it further

RESOLVED: That MSMS work with health insurance carriers to support coverage of costs associated with all stages of the breast reconstruction that may be necessary as well as symmetry operations on the opposite breast in order to restore a woman's body into wholeness.

RESOLUTION 97-96A

Omero S. Iung, MD, Ingham County, for Thomas I. Archambeau, MD

Title: Full Michigan Licensing for Out-of-State Physicians Who Provide Medical Services to Michigan Residents via Telemedicine Services. Referred to the Board for Study.

RESOLVED: That MSMS support the requirement of full Michigan medical licensure for non-resident physicians who provide diagnostic or therapeutic services on a regular, ongoing or contractual basis via electronic or other communications to patients within Michigan; and be it further

Continued on page 25

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1996 Resolutions (continued)

RESOLVED: That MSMS seek legislation requiring full Michigan medical licensure for non-resident physicians who provide diagnostic or therapeutic services on a regular, ongoing or contractual basis via electronic or other communications to patients within Michigan.

RESOLUTION 98-96A

Omero S. Iung, MD, Ingham County, for Thomas J. Archambeau, MD

Title: Hospital Medical Staff Credentialing of Physicians Who Provide Electronic and Other Telemedicine Services for Hospital Patients. Referred to the Board for Study.

RESOLVED: That MSMS support the requirement of physicians who provide diagnostic or therapeutic services on a regular, ongoing or contractual basis via electronic or other communications to patients in a hospital setting within Michigan to be fully credentialed by that hospitals medical staff in accordance with the medical staff bylaws; and be it further

RESOLVED: That MSMS support the requirement of physicians who provide diagnostic or therapeutic services on a regular ongoing or contractual basis to patients in a hospital setting within Michigan solely via electronic or other distant communications (and so would not otherwise ever have any direct personal interaction with the remainder of the medical staff) be credentialed as active members of that hospital's medical staff and be held to the same standards of requisite responsibilities as other active members of the medical staff.

RESOLUTION 99-96A

Carol A. Krieg, MD, Delta County

Title: Create Scope of Practice Board.

Disapproved.

RESOLUTION 100-96A

Ashok R. Sonnad, MD, Gratiot County

Title: No CPR Orders in Adult Foster Care and Assisted Living Settings. Not Accepted as a Late Resolution.

RESOLUTION 101-96A

Andrea D. Gelzer, MD, Hillsdale County, for Michael J. Parks, MD

Title: L-glutamic Acid. Not Accepted as a Late Resolution.

RESOLUTION 102-96A

Devendra K. Sharma, MD, Iosco-Arenac Counties

Title: Equal Medicare Payments to Rural Health Clinics. Not Accepted as a Late Resolution.

RESOLUTION 103-96A

Domenic R. Federico, MD, Kent County, for Douglas A. Mack, MD

Title: Preventing and Remedying Lead Poisoning in Michigan. Approved.

RESOLVED: That MSMS support the following:

1. The timely adoption and implementation of a statewide, comprehensive blood-lead reporting and tracking system, lead registry, urban lead hazard reduction program, and appropriate intervention for children and adults with elevated blood lead levels as recommended by MESB, and

2. The pursuit by the state of all currently available and prospective federal funds, assuring lead abatement is conducted in order to reduce public health risks, and

3. The prompt allocation, beginning no later than 1997, of a share of state environmental cleanup funds for both soil and housing lead cleanup programs, and

4. A partnership among the state, local public health agencies, and physicians to prevent lead poisoning through education and lead cleanup initiatives.

RESOLUTION 104-96A

Joseph R. Oldford, MD, Wayne County

Title: Physician Delegation of Controlled Substances to Physician Assistants. Not Accepted as a Late Resolution.

RESOLUTION 105-96A

Harvey W. Halberstadt, MD, Oakland County
Title: Providing for the Care of Persons With
Mental Illness. Not Accepted as a Late
Resolution.

RESOLUTION 106-96A

Timothy B. Aiken, MD, St. Clair County
Title: Certificate of Need (CON) Reform.

Approved.

RESOLVED: That MSMS endorse the efforts of members who seek an injunction against the retroactive effect of the January 1996 CON rules.

W. Peter McCabe, MD

131st president urges colleagues to speak out, make a difference.

Installation Speech

And, like many of you, I sometimes long for that gusto and idealism I had at the beginning of my career.

But even then it was not without its perils. I can well remember an incident that occurred shortly after I had decided to take up pre-med in college.

I was dancing with my mother at a wedding when she spied an obstetrician named McCaffrey. She tapped him on the shoulder and said, "Jim, we have great news, Peter's going into medicine."

McCaffrey dropped his wife right there on the dance floor and said to us, "Well, that's all fine and good, but it's all going to be socialized in another 2 years, the government's going to run everything, so it won't matter a tinker's damn what you're going into." Well, I was crushed, before I was hardly out of the starting gates. And this was 1957 or 1958, almost 40 years ago! As you know, the best was yet to come.

McCaffrey the obstetrician was about as prophetic in 1957 as my various stockbrokers have been down through the years.

And yet his negativism and cynicism captured a certain thread which continues to infect the profession to this day.

And that's unfortunate, because the challenges we faced then, or face today, are new only in the details. Medicine has always been a tough calling. It takes courage to be a doctor, and that's why I have no doubt that the profession

will not only muddle through, it will rise to new heights of achievement.

Let's look at managed care, the current "bete noire." It poses grave dangers, and many in the Society have been perceptive and articulate in pointing out its

pit falls. But it offers great opportunities too, in making medical care more efficient and effective, in fostering collegiality, and in placing the profession in the driver's seat of its own destiny.

If it's to realize this destiny, however, it must rediscover its humanistic underpinnings. While we've been attaining our technical expertise we've been threatened with loss of our medical souls. I'm not the first to say this. We've had this preached to us by all sorts of members of the choir. But the choir member whom I think has crystallized the challenge more than anyone is our own Jack Kevorkian.

Now believe me, I'm the last to champion Kevorkian. In my book he's been allowed far, far more than Andy Warhol's 15 minutes of fame. But intentionally, or more probably unintentionally, he's forced us to question the limits of our own expertise.

When so much of society seems to support assisted suicide, what is it saying? Are people really that willing to start down the slippery slope, or are they asking us to be more discriminating when we roll out our heavy therapeutic artillery? Do everything you can to save me, Doc, but don't do too much. It's a fine line patients are asking us to discern, but its fineness shouldn't stop us from trying to get it right.

As you know MSMS' policy on assisted suicide, formulated by this House, is to leave the decision to the patient/doctor/family triad.

We all have confidence that the ethical traditions of doctors and their colleagues in the healing arts, supported and constrained by existing law already in place, both civil and criminal, are enough. We don't need more laws



Doctor McCabe at his installation

or judicial interpretations. In fact, a Federal Appeals judge, Guido Calabresi of the 2nd Circuit, could have hit the nail right on the head when he said, "... it may well be that a society may prefer subterfuge and covert practice to trying to draw lines that are extraordinarily difficult to draw."

Instead what we're getting is all kinds of courtroom circuses and conflicting opinions....

... from a legal system which loves to micromanage, but which, even in its best day, from what we doctors have seen many times up close and personal, has a unique ability to mess up a two car funeral. And all the time imbuing our Constitution with the ability to pre-empt moral and ethical judgments. I mean, the Constitution is a fine document, nice for defining property rights and all that, but it's no Koran or Bible. After all, it tolerated and even mandated slavery for 75 years, and even after that it aided and abetted segregation for over three quarters of its existence.

However, at the same time we say "stay out" to the legal system, we must at the same time sharpen our ethical antennae to see that the best interests of mankind are always served.

Another area that should be of continuing concern to the profession is the enormous level of violence in society. We all see its effects in every specialty...pediatricians and family practitioners in family violence, gynecologists in spousal abuse, surgeons and emergency room physicians in street violence...and pathologists in the bodies of homicide victims.

Tom Payne during his presidency directed this Society's attention to family violence, and during my Presidency I would like to extend that theme, but direct attention to the root cause of violence...the American character. Now this may sound like a tall order for a bunch of doctors, and a subject better left to sociologists and political leaders. After all, swashbuckling independence bordering on mayhem has roots

in the American character ranging from as far back as the Minutemen at Lexington and Concord, down through the frontier cowboy, to Dennis Rodman headbutting a basketball referee.

But as characteristic as this may seem, it comes at an enormous social cost, a level of violence that rivals some undeveloped third world nations. And no one sees that social cost more starkly and intimately than we doctors. And we should speak up about it and say, "Enough!". The answer is not more cops with .357 Magnums...it goes deeper than that, to the soul of society, to the loss of plain and simple civility, the sense of having a responsibility to a larger whole more than to just one's own pleasures and self interests. It basically comes down to a concern for your fellow man, and no group champions that more than the medical profession. There must be something we can do.

So we've got the concept, but like a dog chasing a car, what does he do with it once he catches it? What do we do?

One thing that has come to mind is to treat violence in our society as an epidemic, as a public health issue, and bring principles of epidemiology to bear on this cancer which is eating away at the fabric of our society.

But whatever we do, on this or other issues, we as a profession must have the courage to speak up on these and any other issues where we feel we can make a contribution, whether it be managed care, assisted suicide, violence in our society, or any other subject, even if it is controversial. We are all heirs to a great tradition. Singly most of us as individuals are no better than the next person...just ask our spouses.

What sets us apart is the privilege we've been granted to be in a profession whose high standards have been secured by generations of physicians who have gone before us.

During my year in office, I will try, with your help, to continue those traditions.

Thank you very much.

Chair's Report

MSMS Board leads membership in many important arenas

By Peter A. Duhamel, MD, Chair

oresight and planning by the Michigan State Medical Society's Board of Directors, committees and staff yielded a year of unprecedented activity on behalf of physicians and our batients.

Here are just some of our major accomplishments and new initiatives from the past year:

Michigan Patient Bill of Rights introduced

Physician Organizations case study completed

Stop-loss insurance program initiated

Physician Service Organization under consideration

MSMSNET implemented and growing

Evaluation of Michigan Health Plans completed

Third party payer relations strengthened

- Immunization campaign and education program started
- Alliance for Judicial Accountability activated
- Ethical issues in managed care under debate
- Making-the-Rounds to more local hospitals

Membership at an all-time high

- Communications vehicles revamped and increased
- Education programs offered on vital issues

Historical Marker dedicated

- MSMS Strategic Plan updated and new goals added Just briefly, the Strategic Planning Committee -made up of MSMS officers and senior staff--has identified these as top priority goals for 1996:
- Increase young physician membership and participation
- Impact the Michigan Supreme Court races
- Increase growth of electronic communications
- Increase support for Physician Organizations
- Increase non-dues income in order to continue without a dues increase for 3 more years for a total of 9 years (1990-

It's been a tumultuous year since the last House of Delegates and we have more than held our own. The year brings to mind a bit of ancient wisdom: "No one can stop a man with a plan because no one has a plan to stop him." MSMS has planned well, we have implemented our plan and we continue to plan for tomorrow.

Following are some of the details about selected actions by your Board of Directors in 1995-1996.

ACTION REPORT #1 OF THE BOARD OF DIRECTORS

SUBIECT: Resolution 6-95A, "MSMS to Develop Its Own Managed Care Insurance Plan"

REFERRED TO: Reference Committee D

RECOMMENDATION: That the 1996 House of Delegates adopt this report in lieu of Resolution 6-95A, titled "MSMS to Develop Its Own Managed Care Insurance Plan.'

HOD Resolution 6-95A was referred to the MSMS Board of Directors for study. The Resolution requested "that MSMS study the feasibility of developing its own health care insurance company." The Board asked the MSMS Task Force on Physician Networks, chaired by Kenneth H. Musson, MD, to study this resolution and make a recommendation to the Board.

The Task Force on Physician Networks held four meetings to discuss what additional steps MSMS can take to help Michigan physicians succeed in the rapidly changing health care environment. The Task Force carefully considered two alternatives: creation of an MSMS statewide physician network or HMO, or establishment of an MSMS physician services organization (PSO). A PSO, often referred to as a management services organization or MSO, is an entity that provides the infrastructure to help physician organizations, physician hospital organizations and other similar entities provide high-quality, costeffective care in a managed care environment. A PSO also can help physicians manage their practices effectively.

The Task Force carefully studied the alternative of establishing a statewide physician network or HMO. The Task Force concluded that, while this alternative has considerable emotional appeal to physicians, it has several major flaws that preclude it from being an appropriate option for MSMS to pursue. A key problem in establishing an MSMS HMO would be determining who would be allowed to participate in the networks that would contract with the HMO. An MSMS HMO that contracts with networks that limit their membership (through quality or other cost criteria) seriously risks alienating physicians who are excluded from the networks. Adopting an "any willing provider" approach would address the membership problem, but would likely prevent the

HMO from being competitive.

The Task Force identified other significant obstacles to the formation of an MSMS statewide physician network or HMO. First, employers would likely dismiss the concept of an MSMS network or HMO as an attempt at preserving the status quo, rather than as a serious effort to improve the quality and costeffectiveness of health care delivery. Second, MSMS legal counsel warned the Task Force that establishment of an MSMS-sponsored statewide network or HMO would likely raise serious antitrust concerns, particularly with respect to price-fixing. In fact, the AMA's Associate General Counsel informed the Task Force that several state medical society-sponsored networks and HMOs are having antitrust problems, as well as difficulty securing managed care contracts because of skepticism by employers.

In addition, the Task Force believes that health care is basically a local or regional activity. As a result, it believes that MSMS should continue to assist physicians in forming and operating physician-driven, local networks, rather than establish a statewide physician network or HMO. Finally, the Task Force was impressed by the fact that none of the PO leaders from around the country who spoke at the MSMS PO conference in September 1995, recommended that MSMS create its own network or HMO because of the many legal, membership and competitive concerns

involved in doing so.

The Task Force also closely examined the alternative of establishing an MSMS PSO and concluded that MSMS should undertake a PSO feasibility study. The MSMS Board adopted this recommendation at its January 17, 1996, meeting, and a feasibility study is being conducted with a final report to the 1996 MSMS House of Delegates. Key components of the PSO feasibility study are focus groups and a survey of MSMS members to determine interest among Michigan physicians in obtaining services from an MSMS PSO and whether physicians are willing to help capitalize an MSMS PSO. Other major key components of the feasibility study include site visits to successful PSOs to determine PSO success factors and an analysis of the major legal issues involved in forming a PSO.

The MSMS Board of Directors concurs with the report of the Task Force on Physician Networks, and recommends adoption of this report in lieu of House of Delegations Resolution 6-95A.

ACTION REPORT #2 OF THE BOARD OF DIRECTORS SUBJECT:

Resolution 75-95A, "Medicaid Population"

REFERRED TO: Reference Committee D

RECOMMENDATION: That the 1996 House of Delegates adopt this report in lieu of House of Delegates Resolution 75-

95A, titled "Medicaid Population."

House of Delegates Resolution 75-95A requested, "that MSMS develop and present its own plan for providing care to the Medicaid population by physicians in the state of Michigan." The 1995 House of Delegates referred this resolution to the MSMS Board of Directors for study and it was subsequently assigned to the Medicaid Liaison Committee for recommendation.

MSMS and MAOP&S have been involved in the evolution of Michigan's Medicaid system since the development of the

Physician Sponsor Plan (PSP) in the late 1970's.

Currently, MSMS is working with James K. Haveman Jr., Vernon Smith, PhD, Director of Medical Services Administration and newly appointed Bob Semdes, Administrator of Special Projects to discuss possible approaches to a capitated Medicaid

PO and PHO representatives met with Vern Smith, PhD, and Bob Smedes on February 1, and expressed strong interest in contracting directly with Medicaid. In this event, these entities should not be subject to the same solvency requirements as HMO's in order to ensure that they can meet their financial obligations.

Another option MSMS presented to Doctor Smith and Mr. Smedes would be to allow PO's, PHO's and other similar entities to directly contract with Medicaid to accept capitation for professional services only. Because these entities would be at risk for professional services only, they should not be required to comply with the same solvency standards that are imposed on HMO's.

MSMS recognizes that many Medicaid beneficiaries will continue to receive services through HMO's. To ensure that a high percentage of the premium goes to the delivery of health care, Medicaid should include in all of its contracts with HMOs a

provision setting a minimum medical loss ratio.

Provider Sponsored Organization's (PSO) along with Medicaid could establish criteria concerning quality improvement and utilization management mechanisms, credentialling and patient grievance procedures to ensure that only high quality entities

The Physician Sponsor Plan (PSP) has worked well, and for the areas in Michigan that do may not have HMOs, POs, PHOs or other similar entities available it is a good workable alternative.

MSMS will convene additional meetings between Medicaid officials and representatives of Michigan POs, PHOs and interested physicians to continue dialogue on this very important

The MSMS Board of Directors concurs with the report of the Medicaid Liaison Committee and recommends adoption of this report in lieu of House of Delegates Resolution 75-95A.

ACTION REPORT #3 OF THE BOARD OF DIRECTORS

SUBJECT Resolutions 13-95A, 50-95A, 100-95A, and Board Action Report #12

REFERRED TO: Reference Committee A

RECOMMENDATION: That the 1996 House of Delegates adopt this report in lieu of House of Delegates Resolution 13-95A, "Michigan Patient Protection Act," House of Delegates Resolution 50-95A, "Ability Based Criteria for Physicians to Participate as Providers in Health Insurance Programs," House of Delegates Resolution 100-95A, "Patient Protection Act," and Action Report #12 of the Board of Directors, "Resolution 10-94A, 'Any Willing Provider'.'

Resolution 13-95A requested that MSMS include in the

proposed Michigan Patient Protection Act, language proposed by the National Access to Specialty Care Coalition.

Resolution 50-95A requested "that MSMS oppose any restrictions on physician participation with health insurance carriers that are not based on the physicians training and competency," and "that MSMS ask the insurance commissioner to enact rules which would prohibit health insurance companies from using factors unrelated to a physician's ability and training in evaluating the physician for inclusion as a member of their panel of physicians.'

Resolution 100-95A requested "that MSMS support the Michigan Patient Protection Act in that it requires a point-ofservice option allowing patients to seek care outside the network and that it provides various protection for physicians against deselection by plans;" and "that MSMS propose to modify the Michigan Patient Protection Act as suggested by the Patient Access to Specialty Care Coalition representing many non-primary care specialty groups and that these plans must offer point-ofservice in every policy rather than as an option."

Board Action Report #12 addressed Resolution 10-94A, and supported any willing provider provisions as part of the Michigan

Patient Protection Act negotiations.

These resolutions and Board report were referred to the MSMS Board of Directors for further study. The Board of Directors subsequently referred them to the Michigan Patient Protection Act Task Force. The MPPA Task Force discussed these resolutions in depth and recommended various portions of the recommendations be included in the Michigan Patient Bill of Rights. Due to the fact that the Michigan Patient Bill of Rights is an on-going developmental process, the MPPA Task Force agreed that the resolutions be reviewed on a regular basis by the Task Force and continue to recommend changes to the bills as needed.

House Bills 5570-5574 (The Michigan Patient Bill of Rights), were introduced in early February 1996. As introduced, the bills include provisions that would require insurance companies and managed care organizations to provide patients with upfront information about their health plans; prohibit insurance companies and HMO's from excluding coverage based on pre-existing conditions after a period of no more than six months; require insurance companies and managed care organizations to give physicians the opportunity to apply for participation on a health plan panel and if that individual is denied access, the health plan is responsible for explaining to that physician why they were not included on the health plan panel; and would indemnify the physician if appropriate care was denied by a health plan against the wishes of the treating physician. Additional patient bill of rights legislation is expected to be made a part of this important package. MSMS has organized a strong coalition of patient and provider organizations called the Michigan Partners for Patient Advocacy, in order to seek passage of this important legislation.

The MSMS Board of Directors concurs with the report of the Michigan Patient Protection Act Task Force and recommends

adoption of this report.

ACTION REPORT #4 OF THE BOARD OF

DIRECTORS SUBJECT:

Resolutions 10-95A, 67-95A, and 68-95A

REFERRED TO: Reference Committee B

RECOMMENDATION: That the 1996 House of Delegates adopt this report in lieu of HOD Resolution 10-95A, "Liability Coverage for Retired Physicians;" HOD Resolution 67-95A, "State of Michigan Medical Liability Coverage for Volunteer Physicians;" and HOD Resolution 68-95A, "State of Michigan Liability Coverage for Volunteer Physicians and Free Clinics.

Resolution 10-95A requested "that MSMS encourage Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM) to investigate the 'good samaritan' law for its limit on the liability of physicians to provide services on a voluntary basis;" and "that MSMS, if necessary, seek legislation that would limit the liability of physicians who provide services on a voluntary basis;" and "encourage the establishment of MPMLC and PICOM insurance coverage to retired physicians who are former customers in good standing, who retain a medical license and provide medical care on a voluntary basis." Resolution 67-95A requested "that MSMS seek legislation making the state responsible for providing liability coverage to volunteer physicians." Resolution 68-95A requested "that MSMS seek legislation that requires state-provided liability coverage for physicians who provide services at recognized 'free clinics'.'

These resolutions were considered together by the 1995 House of Delegates and were referred to the MSMS Board of Directors for study. The Board subsequently assigned these resolutions to the Committee on State Legislation and Regulations for study and recommendation.

The Committee on State Legislation and Regulations discussed these resolutions as well as the need for the resolutions. Committee members believe that many physicians who would normally provide volunteer care choose not to due to liability concerns. In addition, it was noted that many parts of the state suffer from relatively poor access to volunteer medical care, and expanding the Good Samaritan Act to include volunteer physician care may be one way to address the access problem. Expanding the Good Samaritan Act would give retired physicians the opportunity to utilize their skills as physicians and help alleviate a societal problem.

The Committee on State Legislation and Regulations recommends that MSMS support legislation that would expand the Good Samaritan Act to apply to all volunteer physician

The MSMS Board of Directors concurs with the Committee on State Legislation and Regulations and recommends adoption of this report in lieu of House of Delegates Resolutions 10-95A, 67-95A, and 68-95A.

ACTION REPORT #5 OF THE BOARD OF

DIRECTORS

Resolution 38-95A, "Optometrists: The SUBJECT: Responsibility of the Practice of Medicine'

REFERRED TO: Reference Committee B

RECOMMENDATION: That the 1996 House of Delegates adopt this report in lieu of House of Delegates Resolution 38-95A, "Optometrists: The Responsibility of the Practice of Medicine."

Resolution 38-95A asks that, "MSMS work with the Board of Optometry and other appropriate bodies to formulate educational requirements regarding the specific use of ocular therapeutic pharmaceutical agents;" and "that MSMS seek legislation requiring optometrists to attend appropriate medical education courses.'

This resolution was referred to the MSMS Board of Directors for study and subsequently referred to the Committee on State Legislation and Regulations for recommendation.

The Committee on State Legislation and Regulations discussed this resolution in great detail. Members of the Committee agreed that the practice of optometry needed to be monitored on a continuous basis and legislation should be introduced to ensure that optometrists stay within their scope of practice and are properly monitored. However, Committee members could not agree on exactly how that would be done. Therefore, the Committee on State Legislation and Regulations created a subcommittee that was charged with drafting a recommendation and reporting directly to the Board of Directors.

The MSMS Subcommittee on Optometry Scope of Practice, met via telephone conference call on February 8, 1996. Those participating were Mark D. Kolins, MD, Chair; Patrick Droste, MD; Paul Fecko, MD; Carol Krieg, MD; Michael Sandler, MD; Max Walsh, MD; Joseph Wilhelm, MD; George Williams, MD; Greg Aronin, MSMS Staff; Richard D. Weber, MSMS Legal Counsel and Andrew Lott, MOS Staff.

Subcommittee members discussed the fact that continuing education units are included in the proposed rules that require optometrists complying with the new

scope of practice law increase their educational standards. While most members did not believe that the continuing education requirements were sufficient, they stated that their charge is to develop the most appropriate policy for MSMS and the Michigan Ophthalmological (MOS). While some members believe that MSMS and MOS should move forward with legislation further monitoring the practice of optometry or further reducing the optometry scope of practice, other members expressed their concern that the introduction of legislation could result in amendments that would further expand optometry scope of

Upon further discussion, members agreed that the best strategy would be to prevent optometrists from further expanding their scope of practice and to limit the practice of ophthalmic medicine

to ophthalmologists.

The Subcommittee voted to recommend that MSMS work with the Michigan Ophthalmological Society to limit the practice of ophthalmic medicine to ophthalmologists and support legislation and efforts to achieve this goal.

The MSMS Board of Directors concurs with the conclusions of the Subcommittee on Optometry Scope of Practice and recommends adoption of this report in lieu of Resolution 38-95A.

ACTION REPORT #6 OF THE BOARD OF

DIRECTORS

SUBJECT: Resolution 55-95A, "Presidential Rotation"

REFERRED TO: Reference Committee C

RECOMMENDATION: That the 1996 House of Delegates adopt this report in lieu of House of Delegates Resolution 55-95A, "Presidential Rotation."

The Presidential Rotation Task Force met on September 20, 1995, to discuss MSMS House of Delegates Resolution 55-95A which was referred by the House to the Board of Directors for further study.

The original resolution, submitted by the Oakland County delegation, states:

"Whereas, the distribution of MSMS members has changed significantly in the past twenty years, and

"Whereas, there are now approximately three Outstate

members for each Wayne County member, and "Whereas, the current MSMS presidential rotation reflects an Outstate to Wayne County member distribution of 2:1;

therefore be it "RESOLVED: That MSMS change the rotation of the MSMS

presidency between Outstate and Wayne County to 3:1 with the presidency to be slotted to a Wayne County member in the year of a national presidential election."

The Task Force thoroughly reviewed a number of issues involved with this resolution.

The Task Force first examined membership figures between Wayne County and Outstate since 1981. These figures indicate a slight decline in Wayne County

membership (3,188 in 1981 to 2,948 in 1994). At the same time, however, overall MSMS membership increased from 9,807 to 11,550, resulting in a decreased percentage of Wayne County members; from 32 percent of MSMS membership in 1981 to 25 percent in 1994.

A lengthy discussion ensued regarding MSMS presidential succession beginning with the establishment of MSMS in 1866. After a review of all MSMS presidents and their county memberships, it was indicated that the current three-year cycle actually began in 1884 with only one or two anomalies since that time

The appropriate geographical representation of all other MSMS officers also was discussed by the Task Force. All agreed that such representation has been and is currently very appropriate.

The Task Force also agreed that current MSMS membership levels are strong, particularly when comparisons are made with other states. However, all agreed that membership recruitment will continue to be a priority for MSMS to ensure a strong, aggressive and dynamic organization in the future.

The Task Force concluded that the real goal of MSMS is to increase its membership, and that MSMS should continue to assist Wayne County in its membership recruitment efforts.

As in the past, MSMS will continue to support WCMS in all of its recruitment and retention projects and provide assistance whenever possible. MSMS will continue to attend WCMS Membership Committee meetings and offer support.

The Task Force then developed three recommendations

pursuant to Resolution 55-95A.

The first recommendation is that Wayne County Medical Society be given the opportunity to increase its membership to a minimum of 30 percent with a goal of 33 percent by December 1, 1997. If the 30 percent goal is not achieved, Resolution 55-95A will go into effect as of that date.

The second recommendation is that the Presidential Rotation Task Force meet again after December 1, 1997, to review

membership numbers.

The third recommendation is that if Resolution 55-95A does go into effect, that it not follow the national presidential election cycle as stated in the original resolution.

The Task Force unanimously agreed that these recommendations are a fair and equitable disposition of Resolution 55-95A.

The MSMS Board of Directors concurs with the report from the Presidential Rotation Task Force and recommends adoption of this report in lieu of Resolution 55-95A.

ACTION REPORT #7 OF THE BOARD OF

DIRECTORS

SUBJECT: Resolutions 94-90A, 64-95A, and 102-95A

REFERRED TO: Reference Committee D

RECOMMENDATION: That the 1996 House of Delegates take no action on HOD Resolution 94-90A, "Forward Planning for Medicine," HOD Resolution 64-95A, "MSMS Restructuring," and HOD Resolution 102-95A, "Streamlining of Organized Medicine."

Resolution 64-95A and 102-95A were referred to the MSMS Board of Directors for study and subsequently referred to the Strategic Planning Committee for recommendation. Resolution 94-90A was adopted by the 1990 House of Delegates. At the 1995 House of Delegates, the author of Resolution 94-90A asked that this resolution be sent back to the Board for reconsideration of the Board's approach to this resolution. Resolution 94-90A was also referred to the Strategic Planning Committee for recommendation.

The resolved portions of Resolution 94-90A asks, "that MSMS constitute a standing committee (Think Tank) charged with the contingency planning of viable responses to possible future changes with a time horizon of not less than three years," and "that MSMS ask the AMA to constitute a standing committee (Think Tank) charged with the contingency planning of viable responses to possible future changes with a time horizon of not less than three

The resolved portion of Resolution 64-95A asks, "that the MSMS Board of Directors establish a task force to look at the organizational structure of MSMS, including its relationship to the county organizations and report back in two years (with an interim report in one year) to the House of Delegates on proposed changes that could streamline and increase the effectiveness of the organization."

The resolved portions of Resolution 102-95A ask, "that MSMS establish a task force to look at ways to reduce the costs of running county medical societies," and that MSMS look at ways that could help reduce the duplicative costs incurred in operating state and

multiple county medical societies."

Each of these resolutions call for a standing committee or task force to do what already is being done continuously by the MSMS Strategic Planning Committee, MSMS officers, various MSMS committees and senior staff. It is the opinion of the Strategic Planning Committee that it would be redundant to act on these resolutions individually.

The Strategic Planning Committee, made up of MSMS officers and senior staff, formally meets each one to two years to update the three-year strategic plan with American Medical Association strategic planner Bruce Balfe. Balfe takes the Committee through a detailed discussion of the current "environment," the achievements since the last plan was developed and implemented and a detailed discussion and analysis of what the Committee believes to be the most important

activities and directions for MSMS for the next several years. A written document is prepared by Mr. Balfe and distributed to leadership and senior staff and is available upon request by individual members. Highlights are usually presented in Medigram and Michigan Medicine.

For example, at the most recent Strategic Planning Committee meeting on September 19, 1995, the "must do" list for 1996 included increasing young physician membership, impacting the Supreme Court races to help uphold our

1993 tort reforms, increased growth in electronic capability. providing support for physicians organizations and further increasing non-dues income (to help ensure an eighth year without a dues increase).

The future planning process at MSMS, however, is not a onceevery-year-or-two event. MSMS officers and senior staff work together daily to assess the health care environment, read the membership and make course changes to fulfill the "vision" of the organization. This is an effective process at MSMS that has been bred into leaders and senior staff for decades and has proven again

and again to be effective.

During the most recent year, MSMS leaders and staff have developed and expanded the MSMSNet (more than 10,000 "hits" so far); expanded the "Making the Rounds" program to visit 30 hospital medical staffs; started the Corporate-Affiliated Physicians Committee to respond to a growing area within our membership; joined with Michigan Physicians Mutual Liability Company to offer physicians "stop-loss" insurance for those working with capitated plans; plus many other forward-looking projects proposed and devised by leaders, staff and various committees and task forces.

A recent, potentially sweeping proposal from the Task Force on Physician Networks, for example, is for the establishment of an MSMS Physician Services Organization (PSO). As part of the initial research for this project, MSMS staff is conducting a series of nine focus group meetings with physicians from all over the state to take input and opinions. MSMS is also conducting detailed market research, site visits to other established PSOs and an analysis by legal counsel; all of which are standard operating procedures in an MSMS undertaking of this magnitude. Though the outcome is not yet defined, this is one more example of the thorough planning processes utilized by MSMS.

MSMS senior staff also meet face-to-face with county medical society executive directors annually to discuss ways in which the symbiotic relationship between the entities can be enhanced. MSMS quarterly provides the counties with a guide to

joining or enhancing on-going MSMS activities. MSMS also is connected with the counties through electronic mail and through the Internet. In an effort to reduce staff costs and improve collection efficiency, MSMS does the membership billing for all counties except Wayne County. MSMS staff also meets regularly with county membership committees to discuss ways to increase and maintain membership on the local level. MSMS also assists Oakland County and Muskegon County with staffing of the executive director and secretary, respectively. MSMS is always seeking ways to improve the communication and cooperation between MSMS and the county medical societies.

Additionally, for the past two-and-one-half years, the American Medical Association has undertaken a \$2.5 million study of the entire federation of organized medicine, from county medical societies all of the way through the AMA, to determine how best to improve the efficiency and effectiveness of the federation. More than 250 representatives of the AMA, state medical societies, specialty societies and county medical societies have participated, including 20 from Michigan including MSMS Board member Cathy O. Blight, MD, and MSMS Executive Director William E. Madigan. The completed federation study will be used by MSMS as another tool in planning its own future. To replicate this type of study on the state and county level would be cost prohibitive and redundant.

The MSMS Board of Directors concurs with the report of Strategic Planning Committee and recommends that no action be taken on Resolutions 94-90A, 64-95A, and 102-95A.

ACTION REPORT #8 OF THE BOARD OF

DIRECTORS

Resolution 109-95A, "Encourage Establishment of Compassionate Futile Care Guidelines to be Endorsed by the Medical Profession"

REFERRED TO: Reference Committee F

RECOMMENDATION ONE: That the 1996 House of Delegates adopt this report in lieu of House of Delegates Resolution 109-95A, "Encourage Establishment of Compassionate Futile Care Guidelines to be Endorsed by the Medical Profession."

RECOMMENDATION TWO: That MSMS form a clearinghouse for locally-developed futile care guidelines to serve

as models for others wishing to develop policies.

Resolution 109-95A asks, "that MSMS develop a futile care policy to include the physician's first responsibility to maintain the dignity of their patients at times of impending death by; a) keeping them comfortable, b) not subjecting them to unnecessary tests, c) not subjecting them to treatments which are unproven and/or painful when there is no realistic chance of benefit and which may prolong unnecessary suffering, and d) holding compassionate discussions, among the patient, the physician, the patient's family, and other loved ones." Resolution 109-95A was referred to the MSMS Board of Directors for study and was subsequently assigned to the Committee on Bioethics for recommendation.

The Committee on Bioethics discussed this resolution at length and concluded that the drafting of "compassionate futile care guidelines" by MSMS would not be useful at this time, for reasons elaborated below; but that the Board may wish to consider other means to address these important concerns.

The resolution assumes that physicians and patients and/or their families will agree among themselves on when medical treatment is "futile." In such circumstances, the resolution lists four directives to physicians, which the Committee finds uncontroversial and hardly in need of restatement. But there is a voluminous and heated debate now occurring within the medical literature on futility; and the debate has to do precisely with circumstances in which that assumption does not hold--when physicians disagree with patients or families about what treatments are futile.

That debate reveals the serious controversy about several important points: how is "futility" to be properly defined? Is futility a purely scientific and technical decision or a value-laden and, hence, ethical decision? Should physicians be entitled unilaterally to refuse to offer futile treatment, even over objections of patients or families? How should disputes over futility determinations be resolved in health care settings? Is futility a matter of professional principle, cost containment, or perhaps both?

The Committee on Bioethics finds that the present state of controversy would make any "futile care guideline" issued by MSMS of dubious value, assuming that the guideline did attempt to grapple with the serious ethical concerns. The best

MSMS could do would be to summarize the relevant literature and suggest that interested physicians read that literature in order

to make up their own minds.

On the other hand, some believe that the ultimate resolution of the futility debate will occur not when the authors of journal articles stop disagreeing, but when hospitals and other institutions develop practical policies for working out futility disagreements at the local level. A number of Michigan hospitals have developed such policies. MSMS may wish to consider whether it wants to form a central repository or clearing house for such policies to provide possible models for institutions considering policies of their own. This may ultimately be a more useful resource than a written

ACTION REPORT #9 OF THE BOARD OF

DIRECTORS SUBJECT:

Board Action Report #10, "Statement on Integrity and the Values and Principles Embedded in the Tradition of Medicine"

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REFERRED TO: Reference Committee F

RECOMMENDATION: That the 1996 House of Delegates adopt the attached amended Bioethics Committee Report on Integrity and the Values and Principles Embedded in the Tradition

of Medicine in lieu of Board Action Report #10.

MSMS Board Action Report 10 recommended, "that the 1995 House of Delegates adopt the Bioethics Committee Report on Integrity and the Values and Principles Embedded in the Tradition of Medicine as the MSMS statement on the ethics involved in the health system reform debate, and approve the publicizing of this statement to the members and the public." The House referred Action Report 10 back to the Board for study, and it was subsequently sent back to the Committee on Bioethics for recommendation.

Objections to the original two-part report from the Committee on Bioethics on ethical issues surrounding health care reform caused the Committee to review the document and amend it for

The Committee eliminated the numerical listing of "Core Values in the Tradition of Medicine" and the portion dealing with "Ethical Principles Involved in Health Care Reform" and would like to resubmit the narrative portion of the report on "Integrity and the Values and Principles Embedded in the Tradition of Medicine."

Objections to the other portions came from Gerald H. Mandell. MD, and after several written and verbal communications with him by James Waun, MD, Committee Vice Chair, the Committee agreed that much confusion could be eliminated by amending the original report.

The MSMS Board of Directors concurs with the recommendation of the Committee on Bioethics and recommends adoption of the statement on integrity and the values and principles embedded in the tradition of medicine.

Attachment

ATTACHMENT TO ACTION REPORT #9 OF THE **BOARD OF DIRECTORS**

BIOETHICS COMMITTEE REPORT ON INTEGRITY AND THE VALUES

AND PRINCIPLES EMBEDDED IN THE TRADITION OF MEDICINE

Integrity is a wholeness or bound-together-ness that provides the basis for identity of persons and institutions or groups. A physician with integrity has a reasonably full, relatively stable and coherent set of highly cherished personal and professional values and principles that identifies him/her as a professional and a person. By consistently and truthfully expressing and acting according to his/her values and principles and demonstrating a commitment to them he/she provides a basis for others to know, respect, trust and rely on him/her. A medical society's commitment to the values and principles of the tradition of medicine provides a basis for society's respect, trust and reliance upon it.

Certain values and principles constitute the core of the tradition of medicine: EMPATHY and COMPASSION while relieving pain and suffering, ACCURACY and RELIABILITY in applying scientific knowledge of the day to health problems, FIDELITY, and COMMITMENT TO CONTINUOUS SELF

EDUCATION AND IMPROVEMENT.

As society became more complex the ancient medical principle of FIDELITY changed from its initial focus on physicians' responsibilities to individual patients to include duties as advocates for public health and for fair and just provision of medical services to all who need them. Physicians' duties to individual patients have also become more complex. Along with protecting patients' appropriate privacy and confidences and placing their medical interests and needs above our own personal interests we now also have a duty to empower patients to make autonomous, informed decisions about medical care, to respect their right to competently accept or reject medical therapy, and to help them plan and carry out appropriate therapy at the end of life. Discharging this duty requires openness, honesty, disclosure of relevant information and providing appropriate expert opinions and recommendations. Physicians providing primary care have additional duties to conscientiously coordinate complex care plans and arrange for continuity of care for their patients.

From their training individual physicians acquire professional values, principles and duties and augment them with their own set of personal values and principles. Personal and professional life brings inevitable conflicts among our values and principles, requiring their periodic modification and change. A full, completely integrated and static or stable set of personal moral values and principles is not possible.

A medical society has an educational duty to encourage and maintain the competence and continual self educational improvement of its members and an advocacy duty for the protection of the integrity of the physician-patient relationship from outside interference, for public health generally and the public health aspects of social issues, and for the just and fair provision of medical services to all who need them.

ACTION REPORT #10 OF THE BOARD OF DIRECTORS

SUBJECT: Development of An MSMS Management Services Organization (MSO)

REFERRED TO: Reference Committee D

RECOMMENDATION ONE: That MSMS take, as soon as possible, the steps necessary to establish a for-profit MSO subsidiary to help MSMS succeed in the changing medical practice environment.

RECOMMENDATION TWO: That MSMS provide a line of credit to the MSO of up to \$500,000 from its Capital Reserve Fund for start-up capital with the intent that the stock offering in the new entity be made as soon as possible.

Your Board of Directors met this afternoon and considered the attached report from the Task Force on Physician Networks. After careful and thorough discussion, your Board of Directors approved the Task Force recommendations to proceed with development of a Management Services Organization (MSO).

An MSO provides infrastructure and support services for physicians to negotiate and manage risk and other insurance contracts. MSO services can include: management information systems, contract analysis and negotiation, contract analysis and negotiation, credentialling, provision of stop-loss and other managed care insurance products, utilization management and quality assurance programs, claims adjudication and actuarial services. These services provide means for physicians to deal more effectively with payers.

Developing an MSO is a capital-intensive undertaking. Your Board of Directors is recommending a loan for start-up capital of up to \$500,000, with the intent of offering stock in the MSO to Michigan physicians, upon completion of a detailed business plan and prospectus. Your Board recognizes there are risks inherent in moving forward with this financial commitment, but believes these risks are far outweighed by the danger of inaction. The feasibility study described in the report highlights MSMS member needs for many MSO services. MSMS must act quickly to provide these services, to assure that physicians can obtain them from an organization whose priorities are clearly the interests of physicians and their patients. Additionally, our development of an MSO provides the opportunity for MSMS to network with existing organizations providing those services.

If approved by the House, the next steps for the Board will include assessing possible MSO service providers, planning member education programs and developing a detailed business plan. We must act, on behalf of our members, to give physicians the tools they need to regain a strong voice in our health care

system.

B. David Wilson, MD

Outgoing MSMS president challenges: continue to look for excellence in leadership

Exaugural Address

quote from Thomas Paine, the American patriot, not the past MSMS president: "These are the times that try men's souls."

Paine and his 1776 compatriots were fighting for their freedom, fighting tyranny, fighting oppression.

> We are involved in a similar fight today. We are fighting for the right to practice medicine the way only physicians know how to practice medicine. We are fighting for our profession's rightful place in the changing health care delivery system.

> And we are fighting for our patients' rights, as well.

> The patriot Tom Paine wrote further: "The summer soldier and the sunshine patriot will, in this crisis, shrink from the service of his country; but he that stands it now deserves the love and thanks of man and woman."

In this health care revolution, we are the patriots; we are the soldiers.

We must stand united, for our profession, for our

Throughout my involvement with organized medicine. I have always considered myself a good soldier. I never initially aspired to the presidency of MSMS. I was a worker. I was in the trenches. I followed the lead of those I respected. I did my duty. But over the years as my comrades fell by the wayside, I found myself with a battlefield promotion. I stand here today as your seasoned leader, with 24 hours left in my command.

This lofty Position for the past year has given me a pretty good view of the battlefield. Let me share just a little of what I have seen this year and then a little of the "vision thing" from a foot

soldier who has made good.

Let's look at the biggest bugaboo first; managed care.

It may be a problem. If it grows and is implemented as it is in

other states, we, and our patients, are in trouble. But we, meaning you and me and our colleagues back home as members of MSMS, already are involved in shaping managed care in Michigan.

The phrase itself has some very heavy baggage. Many people think of managed care simply as cutting services to cut costs. And all too often. that is how it evolves.

But we have to reshape it into the management of care. We have to be cost conscious, but we also have to look at each patient, individually, wholly, to determine what is going to be the most effective treatment.

Is it more cost-effective to treat with an expensive, one dose antibiotic and get that patient cured and back to work? Is that extra test going to give us the data we need to make the most effective diagnosis, or is it just a few extra bucks in the bank?

We need to embrace the management of care. We need to study outcomes. We need to emphasize prevention. We need to deliver quality care. We need to keep our patients healthy. We need to be involved in the whole health care delivery system, not just be bit players.

Primary care givers and specialists must work together, to give cost efficient care without respect to their individual turfs. We have to get away from payment only for procedures but do only the procedures which will change treatment or cost effectively manage patient care.

Every single day your Michigan State Medical Society works hard to keep physicians in the ball game, as management and owners, not just players. I know because, as president, I review all correspondence and communications and it pours into my fax machine every day, all day long.

I can tell you how heavily we are involved in health care and in shaping policy. Over a ream



Doctor Wilson addresses the House

of paper a week, that's how heavy that correspondence is to policy makers and leaders.

Our committees are on fire. We have a finger in every pot out there. From medical economics to legislation, form bioethics to education, your medical society is fighting for you, your profession and your patients.

Right after World War Two, General George Marshall wrote, "It is not enough to fight. It is the spirit which we bring to the fight that decides the issue. It is morale that wins the victory."

Our morale is high. We are a thriving State Medical Society. We are increasing membership to record numbers, while other states decline.

Because we empower our members, we give them a forum and the authority and ability to enact change. First within the medical society, and then throughout society in legislation, education or influence.

We are offering value to our members. We are offering a niche for everyone. We are meeting the needs of our various groups and in doing so, creating a whole greater than the sum of its parts. We are synergistic. Our energy is contagious. We have made ourselves a force with which to be reckoned.

We are, indeed, a visionary Medical society. We don't just keep our eyes on the horizon, we send reconnaissance people over the horizon to report back on the future. Then we plan for it. Then we shape it. Then we live it.

I want to conclude with my limited vision for the future of MSMS, from years as a foot soldier and one as President. It is not about specific outside issues confronting us. It is about inside issues.

Not many of you here realize that in three years, most of the "old guard" will be off the MSMS Board of Directors. Our terms are expiring. We are moving on. As we go, we take with us our "institutional memory." But in place, we get fresh, new ideas, energy and enthusiasm.

I feel good about the current and developing

leadership of MSMS. We have a deep bench. Our farm clubs are good.

My request is that you continue to look for excellence when electing your leadership. Elect candidates who know that they must continually look for ways to serve our constituencies, and our potential constituencies.

We must continue to look for ways to provide a perceived value. And once we have it, we must continually sell it to members and non-members. We must vigilantly pay attention to the needs of our members. And then act accordingly.

General George Patton said, "Wars may be fought by weapons, but they are won by men. It is the spirit of men who follow and of the man who leads that gains the victory."

Comment Line

If you would like to comment on an article in Michigan Medicine, or any other aspect of the magazine, please contact Judy Marr, Manager, Communications and Professional Relations, at (517) 336-5744, or by FAX at (517) 337-2490, or E-mail at jmarr@msms.org

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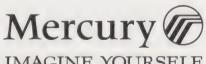
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AWARDS

MSMS Honors Outstanding Physicians

National Presidents Awards

Awards were presented to the following for their service as presidents of national medical organizations:

John D. Baker, MD, President, American Association for Pediatric Ophthalmology and Strabismus, *Dearborn*T. Yamada, MD, President, Central Society for Clinical Research, *Ann Arbor*

Jason H. Bodzin, MD, President, Midwest Surgical Association, Bingham Farms, MI

N. W. Thompson, MD, President, Western Surgical Association, Ann Arbor

Presidential Citations

This award, presented to physicians or lay persons who have made an outstanding contribution to medicine in the state, was presented to:

Frank B. Walker, MD, St. Clair Shores Senator Dan L. DeGrow, Port Huron

Frederick and Besse Moulton Plessner Memorial Award

This award is presented by the MSMS Board of Directors to a rural physician who "best exemplifies the practice and ethics of a rural country practitioner." This year's recipient was:

Miriam S. Daly, MD, Albion

House of Delegates Certificate of Appreciation

This award, given to MSMS members for their past service on the Michigan Delegation to the American Medical Association, was presented to: Louis R. Zako, MD, Harbor Springs

50 Year Awards

Mildred A. Axelrod, MD, Southfield Walter F. Baer, MD, Grosse Pte. Joseph A. Barss, MD, Bellevue, WA



1995-96 MSMS President B. David Wilson. MD, presented an MSMS presidential citation to Frank B. Walker, MD (left), who retired this year from the AMA Board of Trustees after 25 years of service to organized medicine.



Senator Dan L. DeGrow (R-Port Huron), (left), received a presidential citation for his instrumental role in passage of Michigan's medical liability tort reform.

Stanley L. Barton, MD, Trenton Guillermo Betanzos, MD, St. Clair Shores

Michael H. Bialik, MD, Dearborn
F. Ross Birkhill, MD, Dearborn
Rosemarie Blosen, MD, Grosse Ile
Vernon L. Boersma, MD, Holland
Russell P. Bolton, MD, Bloomfield Hills
Charles E. Boonstra, MD, St. Joseph
Leon R. Boruch, MD, Lapeer
Eugene M. Brooks, MD, Bloomfield Hills
Eli M. Brown, MD, Bloomfield Hills
Robert E. Campbell, MD, Peoria, IL
Ralph E. Carlson, MD, Florence, WI
Robert L. Clark, MD, Fenton

Joel W. Clay, MD, Mt. Clemens Jerome F. Cordes, MD, Lansing Thomas N. Cross, MD, Ann Arbor Robert J. Crossen, MD, Williamsburg, VA

William P. Curtiss, MD, Grosse Pte. Shores

William J. Dinnen, MD, Port Huron Henry M. Domzalski, MD, Detroit Johan W. Eliot, MD, Ann Arbor Frederick W. Engstrom, MD, Dearborn Jack A. Fiebing, MD, Traverse City Leo S. Figiel, MD, Atlantis, FL Silvio P. Fortino, MD, Okemos Max L. Gardner, MD, Grosse Pte.

AWARDS



MSMS 1996 50 Year awardees gathered for their official portrait.

Robert R. Garneau, MD, Ludington Robert A. Gerisch, MD, Detroit Anthony C. Gholz, MD, Port Huron Virgil P. Goodman, MD, St. Clair Shores James H. Grove, MD, Niles Benjamin F. Haddad, MD, Detroit William J. Hanley, MD, Muskegon Everett R. Harrell, MD, Ann Arbor Robert J. Hartquist, MD, Coldwater Roy S. Hazen, MD, Beverly Hills Robert G. Heneveld, MD, Naples, FL D. Bonta Hiscoe, MD, East Lansing Willard E. House, MD, Rochester M. Colton Hutchins, MD, Bloomfield Hills

Lyle F. Jacobson, MD, Santa Rosa, CA Wayne N. Jacobus, MD, Naples, FL Harold W. Jaffe, MD, Troy Walter J. Jaracz, MD, Grand Rapids Viggo W. Jensen, MD, Santa Barbara, CA

Richard S. Kamil, MD, West Bloomfield Albert J. Kaspor, MD, Grosse Pte. Woods Louis W. Kaufman, MD, Bloomfield Hills Lawrence J. Kelly, MD, Grosse Pte. Woods

Harold F. Kendrick, MD, Waterford, MD Charles Kessler, MD, Huntington Woods Clifford S. Kozlow, MD, Fountain Hills, AZ

Kenneth L. Krabbenhoft, MD, Pleasant Ridge

Bernard Krakauer, MD, Southfield Seymour Krevsky, MD, Birmingham Louis J. La Joie, MD, Detroit

David C. Laderach, MD, Grosse Pte Vance B. Lancaster, MD, Bend, OR John L. Langin, MD, Bay City Jules C. Lassignal, MD, Saginaw Morris J. Lipnik, MD, Southfield John G. Lipski, MD, Beverly Hills, FL John F. MacGregor, MD, Owosso Andrew D. Mann, MD, East Pointe Stephen C. Mason, MD, Ann Arbor Norman L. Matthews, MD, Marquette Stephen G. May, MD, Okemos William G. McDonald, MD. Dearborn John F. McGuire, MD, Fort Myers, FL James A. McLean, MD, Ann Arbor Augustus W. Mitchell, MD, Detroit Joe D. Morris, MD, Ann Arbor Elmer J. Mueller, MD, Birmingham William J. Muesing, MD, Ferndale, Lambertus Mulder, MD, Muskegon, Katheryn L. O'Connor, MD, Southfield Donald C. Overy, MD, Pontiac Delmo A. Paris, MD, Grosse Pte. Woods William H. Plesscher, MD, East Lansing Robert Rapp, MD, Ann Arbor Rudolph E. Reichert, MD, Ann Arbor Kenneth L. Repola, MD, Saginaw George A. Roberts, MD, Birmingham Joseph T. Sadzikowski, MD, Dearborn Heights

Donald R. Schimnoski, MD, Three Rivers

Marrion U. Scott, MD, Harper Woods Charles R. Sempere, MD, Iron Mountain

Philip G. Seven, MD, Roanoke, VA

Guy W. Sewell, MD, Roseville Frederick F. Shevin, MD, Bingham Farms

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George D. Stilwill, MD, East Lansing Raymond Stoller, MD, N. Miami Beach, FL

John H. Stunz, MD, Bloomfield Hills Edwin C. Sundell, MD, Okemos Frank G. Talbot, MD, Clarkston Glenn F. Tomsu, MD, Jeddo Kenneth H. Trader, MD, Northville Clarence F. Webb, MD, Grand Rapids Herschel J. Wells, MD, Copemish Robert R. Yoder, MD, Mountain Home, AK

John H. Young, MD, Traverse City Hermann A. Ziel, MD, Shaftsburg Margaret Z. Zolliker, MD, Dunwoody,

MSMS names life, retired members

LIFE MEMBERS — Members who have maintained an active membership in good standing for twenty-five years in any one or more constituent state societies of the American Medical Association, with any five years in Michigan, with dues paid for the previous calendar year and who 1) have attained the age of 70 years or 2) have been in practice for 50 years.

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Mary V. Daly, MD

CHIPPEWA-MACKINAC

Hugh R. Allott, MD Donald P. Baker, MD

GENESEE

Burt A. Parliament, MD

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CALHOUN

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66 physicians debated 106 resolutions

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The following is a half-day continuing medical education program sponsored by Blue Cross Blue Shield of Michigan and presented by the Medical Staff, Michigan Heart and Vascular Institute, St. Joseph Mercy Hospital, Ann Arbor.

"Myocardial Revascularization: Patient Selection / Treatment Options / Follow-up"



Saturday, September 7, 1996



Location

Blue Cross Blue Shield of Michigan Metro Service Center – Auditorium 27000 W. Eleven Mile Road, Southfield, MI

Registration

Call: Lee Singleton, Office of Continuing Medical Education (313) 225-0163

Deadline for Registration: August 30, 1996

Fee

Pre-registration required.

Participating Blue Cross Blue Shield of Michigan physicians—No fee. Non-Participating Blue Cross Blue Shield physicians—\$15.00 by check payable to Blue Cross Blue Shield of Michigan – CME.

Send check to:

BCBSM, Office of CME 600 Lafayette East, MC 0710 Detroit, MI 48226

Purpose and Intended Audience

This seminar on myocardial revascularization will provide an overview of a variety of patient presentations with myocardial ischemia; acute and chronic, in the office, the emergency department and the hospital. The clinical and laboratory methods for identification of those individuals for whom myocardial revascularization is the most appropriate therapy will be highlighted. The post intervention follow-up and management of these patients, often the responsibility of the primary care physician, will be addressed. Several clinical algorithms incorporating scientifically based/cost effective management will be presented.

This conference is open to all physicians.

Objectives of the Conference

At the conclusion of the program, the participants should be able to:

- Identify the broad indications for myocardial revascularization related to symptom control and survival advantage.
- Define the selection criteria for obtaining the best functional or stress test for specific patients.
- Outline the appropriate work-up and evaluation of patients with unstable angina and identify those who are candidates for revascularization.
- Describe issues related to thrombolytic therapy versus angioplasty for treatment of acute myocardial infarction.
- Understand the benefits of the use of arterial conduits for coronary bypass surgery.
- Have a greater understanding of the application of the newer percutaneous coronary interventions.
- Understand the rationale for non-invasive testing and management of patients after revascularization.
- Identify the reasons to lower cholesterol in patients with coronary artery disease.

The views and opinions expressed by the speakers/panelists do not necessarily reflect those of BCBSM or current BCBSM medical policy.

Program Agenda

7:15 AM Continental Breakfast

7:55 AM Welcome CME Program Director John J. Siller, M.D.

8:00 AM Introduction and Overview Program Director and Moderator Ron J. Vanden Belt, M.D.

The Office Patient

8:15 AM Clinical Assessment/Triage Bradley L. Hubbard, M.D.

8:35 AM Selecting the Appropriate Functional Test Benjamin D. McCallister, Jr., M.D.

The Hospital Patient

8:55 AM Emergency Department Triage/ The Chest Pain Center Bruce Genovese, M.D.

9:15 AM Unstable Angina Stuart A. Winston, D.O.

9:35 AM Acute Myocardial Infarction Kurt J. Holland, M.D.

9:50 AM Panel Discussion

10:10 AM Break

The Cath Lab and Operating Room

10:30 AM Bypass or Angioplasty for my Patient Stephen E. Rosenblum, M.D.

10:45 AM Bypass: Emerging Techniques/Advantages of Arterial Conduits
Richard L. Prager, M.D.

11:05 AM Angioplasty: Newer Techniques: Rotablator/Stents/ Ultrasound Michael J. O'Donnell, M.D.

Back in the Office

11:25 AM Post Revascularization: Treatment and Testing Bradley L. Hubbard, M.D.

11:45 AM Decrease the Long Term Risk: Lower the Lipids Ron J. Vanden Belt, M.D.

12:05 PM Panel Discussion

12:30 PM Adjourn

Credit Hours

Blue Cross Blue Shield of Michigan, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for a maximum of four (4) credit hours in Category I toward the requirements for Michigan relicensure and toward the Physician's Recognition Award of the AMA provided it is completed as designed.

AOA 1-A Credit sponsored by Pontiac Osteopathic Hospital.

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Speaker's Report

1995 MSMS resolutions became actions

By Gary D. Maynard, MD, and Dorothy Kahkonen, MD

S ince passage of 1995 House of Delegates resolutions, MSMS committees, Board and staff have been hard at work turning these directives into actions. Here's what happened:

1-95A Title: Tort Reform and the Tobacco Industry. Adopted as Amended.

This resolution requested that MSMS oppose any tort reform legislation that would exclude tobacco industries or tobacco products from liability.

HB 4508 and SB 344 provide for overall product liability reform. This legislation provides for a cap on non-economic damages, scientific testimony requirements, elimination of joint and several liability except in the cases of medical malpractice cases, changes in venue, and other specific product liability reforms. While it is not clear how this legislation would apply to the tobacco industry, certain lawmakers did seek amendments that would specifically exclude the tobacco industry. Due to certain political realities of such complicated legislation, this endeavor did not meet with success. However, MSMS was successful in retaining joint and several liability for all defendants in medical malpractice cases.

MSMS continues to advocate for strong anti-tobacco legislation such as legislation that would repeal the law prohibiting local units of government from implementing tobacco related ordinances that are stronger than the state's law, legislation licensing tobacco retailers, legislation that would prohibit smoking in the work place, and legislation that would prohibit billboards advertising tobacco products. MSMS is also opposing legislation that would alter the Youth Tobacco Act in a manner that is expected to provide no results. This legislation is supported by tobacco retailers and is expected to be supported by the tobacco industry. MSMS will continue to work with the Tobacco Free Michigan Action Coalition to enact significant anti-tobacco legislation.

This resolution also directed MSMS to ask the AMA to oppose any tort reform legislation that would exclude tobacco companies or tobacco products from liability.

The Michigan Delegation to the AMA forwarded the resolution to the Annual Meeting of the AMA in June 1995, where it was combined with another, similar resolution. The AMA House passed a substitute opposing any tort reform legislation that would exclude tobacco companies or products from liability or special protection.

2-95A **Title: Revision of Michigan Medical Examiner System.** Adopted as Amended.

This resolution asked MSMS to support revision of the Michigan Medical Examiner system and further requests that MSMS work collaboratively with the Michigan Association of Medical Examiners, the Michigan Society of Pathologists, and other appointed officials and organizations deemed useful to this revision of the Medical Examiner system.

MSMS has worked closely with leaders of the Michigan Association of Medical Examiners to pursue revisions of the Michigan Medical Examiner system. MSMS and MAME will soon host a meeting including the Michigan Society of Pathologists, and other necessary organizations in order to discuss the appropriate steps to revise the Michigan Medical Examiner system. MSMS is dedicated to committing the necessary resources in order to pursue this very important project.

3-95A Title: Deductibility of Continuing Medical Education (CME) for Retired Physicians. No Action.

4-95A Title: Medical Staff Participation in Hospital Merger Negotiations Recruitment and Employment of Physicians and Selection of Senior Administrative Officers. Substitute Resolution (in lieu of 4-95A and 9-95A). Adopted.

This resolution asked MSMS to encourage medical staffs to play a meaningful role in the administration of the hospital including involvement in hospital merger negotiations, participation in the selection of senior administrative officers including the Chief Executive Officer and that MSMS advocate that medical staffs include in their corporate bylaws an article to assure the involvement of the medical staff and the appropriate primary and specialty care physicians whenever the governing body considers and undertakes the recruitment and employment of physicians. The resolution also requested that MSMS educate Michigan physicians regarding these matters.

The resolution was referred to the MSMS/HMSS Governing Council. The Governing Council has responded to many requests for assistance from medical staff officers and physicians to assist them in developing a plan for participation of the medical staff in the merger or acquisition of their hospital. There also have been employed physicians and physicians in private practice assisted by the Governing Council in developing a protocol to assist them in the employment of new physicians and their incorporation into the medical staff and community patient referral patterns. On three occasions the Governing Council has advised medical staff officers regarding their involvement with the hospital administration and governing body pertaining to the interview process and hiring of new senior administrative officers. MSMS/HMSS has incorporated into the Making the Rounds Program (MTR) a consulting opportunity for medical staff physicians who are threatened by the mergers, acquisitions and general realignment of physician practices. On many occasions physicians have consulted with the MTR team which has been of assistance in encouraging physician participation and directing physician involvement.

The resolution and Governing Council recommendations were communicated to the Michigan Health and Hospital Association where it was reviewed by its Council of Physicians

The Council of Physicians suggested that in the current environment, it is "good business practice" to involve physicians in such activities. Exception was taken to the use of the word "insist" in the second RESOLVED, as the Council of Physicians suggested that improved communications between the medical staff and administration was the desired outcome, and such language could potentially create a defensive environment. The Council of Physicians recommended that MSMS and MHA continue to work together to develop programs on productive physician-hospital communication and collaboration pertaining to this resolution.

5-95A Title: Summary of Suspension of a Physician's License Following a Successful Conviction of a Misdemeanor Involving Possession or Use of Alcohol. Substitute Resolution (in lieu of 5-95A, 26-95A and 78-95A). Adopted.

This resolution asked that MSMS seek legislation to amend Section 16233.5 of the Michigan Public Health Code in regards to the discriminatory summary suspension of health professionals' licenses or registrations upon the conviction of a misdemeanor involving alcohol.

House Bill 5091, which effectively amends Section 16233 of the Public Health Code by establishing due process, was signed by Governor Engler on November 20, 1995, and was assigned Public Act #196 of 1995.

The amended law establishes due process between the time of the misdemeanor conviction and the suspension of a health care professional's license. The new language allows the Department of Commerce to investigate whether or not the misdemeanor adversely affects the licensee's ability to practice in a safe and competent manner, and if the Department determines that the public health, safety, or welfare requires emergency action, the

Department may summarily suspend the licensee's license.

MSMS was very instrumental in seeking and passing HB 5091, along with a coalition of other health care organizations, including the Michigan Association of Osteopathic Physicians and Surgeons, the Michigan Dental Association, the Michigan Nurses Association, and the Michigan Health and Hospital Association.

Title: MSMS to Develop its Own Managed Care Insurance Plan. Referred to the Board for Study.

This resolution asked that MSMS study the feasibility of developing its own

health care insurance company.

The Task Force carefully studied the alternative of establishing a statewide physician network or HMO. The Task Force concluded that, while this alternative has considerable emotional appeal to physicians, it has several major flaws that preclude it from being an appropriate option for MSMS to pursue. A key problem in establishing an MSMS HMO would be determining who would be allowed to participate in the networks that would contract with the HMO. An MSMS HMO that contracts with networks that limit their membership (through quality or other cost criteria) seriously risks alienating physicians who are excluded from the networks. Adopting an "any willing provider" approach would address the membership problem, but would likely prevent the HMO from being competitive.

The Task Force identified other significant obstacles to the formation of an MSMS statewide physician network or HMO. First, employers would likely dismiss the concept of an MSMS network or HMO as an attempt at preserving the status quo, rather than as a serious effort to improve the quality and costeffectiveness of health care delivery. Second, MSMS legal counsel warned the Task Force that establishment of an MSMS-sponsored statewide network or HMO would likely raise serious antitrust concerns, particularly with respect to price-fixing. In fact, the AMA's Associate General Counsel informed the Task Force that several state medical society-sponsored networks and HMOs are having antitrust problems, as well as difficulty securing managed care contracts because of skepticism by employers.

In addition, the Task Force believes that health care is basically a local or regional activity. As a result, it believes that MSMS should continue to assist physicians in forming and operating physician-driven, local networks, rather than establish a statewide physician network or HMO. Finally, the Task Force

was impressed by the fact that none of the PO leaders from around the country who spoke at the MSMS PO conference in September 1995, recommended that MSMS create its own network or HMO because of the many legal,

membership and competitive concerns involved in doing so.

The Task Force also closely examined the alternative of establishing an MSMS MSO and concluded that MSMS should undertake a MSO feasibility study. The MSMS Board adopted this recommendation at its January 17, 1996, meeting, and a feasibility study is being conducted with a final report to the 1996 MSMS House of Delegates. Key components of the MSO feasibility study are focus groups and a survey of MSMS members to determine interest among Michigan physicians in obtaining services from an MSMS MSO and whether physicians are willing to help capitalize an MSMS MSO. Other major key components of the feasibility study include site visits to successful MSOs to determine MSO success factors and an analysis of the major legal issues involved in forming a MSO.

7-95A Title: Interstate Pharmacy Ordering Privileges. Adopted as Amended.

This resolution called on the AMA to conduct an inventory of state laws pertaining to interstate pharmacy ordering privileges and to advise physicians in Michigan, and those in other states, of the results.

The AMA Reference Committee heard extensive and balanced testimony on the problem outlined by this resolution and the approach taken in the resolution. Testimony was heard on the problems that patients face when they attempt to fill a prescription in a different state from where the prescribing physician practices and holds a license. These individuals favored the resolution's approach of the AMA conducting an inventory of state laws to provide to physicians and the states. However, there was considerable testimony that questioned the efficacy of the AMA conducting an extensive survey of state laws and whether physicians would access such a compilation when writing prescriptions. In addition, there was some concern expressed about need to gather more information about ancillary licensure and quality of care issues that arise when a physician's practice of medicine extends across state lines. Finally, the Committee agreed with the testimony indicating that in visiting this issue, the Board of Trustees should determine the methods for addressing this problem that will best meet the needs of both physicians and patients.

Title: Copays and Deductibles. Approved. 8-95A

This resolution asked MSMS to seek full payments to physicians for services to these insured patients and that third party payers be responsible for collecting the copays and deductibles from these insured members.

This matter has been the subject of discussion among MSMS physicians, staff and insurance company representatives. Insurers continue to believe the physician is in the best position to collect the copayments at the time of the patient visit. Therefore, there is no interest among insurers to consider this

Physician Participating in Hospital Network Selection of 9-95A Administration. Substitute Resolution (in lieu of 4-95A and 9-95A). Adopted. See Resolution 4-95A.

10-95A Title: Liability Coverage for Retired Physicians. Referred to the Board for Study.

This resolution requested that MSMS encourage Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM), to investigate the Good Samaritan Law for its limit on the liability of physicians to provide services on a volunteer basis and that MSMS if necessary, seek legislation that would limit the liability of physicians who provide services on a volunteer basis and that MSMS encourage the establishment of MPMLC and PICOM insurance coverages to retired physicians who are former customers in good standing, who retain a medical license and provide medical care on a volunteer basis.

This resolution was referred to the MSMS Board of Directors for further study. The MSMS Board of Directors then referred this resolution to the MSMS Committee on State Legislation and Regulations. The Committee on State Legislation and Regulations reviewed this resolution at their January 31, 1996, meeting.

Committee members believe that many physicians who would normally provide volunteer care choose not to due to liability concerns. In addition, it was noted that various parts of the state suffer from relatively poor access to volunteer medical care, and expanding the Good Samaritan Act to include volunteer physician care may be one way to address the access problem. Expanding the Good Samaritan Act would give retired physicians the opportunity to utilize their skills as physicians and help alleviate a societal problem.

After a great deal of discussion, the Committee recommended to the Board of Directors that MSMS support legislation that would expand the Good Samaritan Act to include physicians providing volunteer care. MSMS has discussed this matter with lawmakers who have agreed to sponsor legislation at the appropriate time.

Title: Investigation of Not-for-Profit Hospital Tax Exemption.

This resolution asked MSMS to seek legal and/or legislative clarification as to the extent of tax exemption of not-for-profit hospital owned/controlled activities that are only marginally related to its inpatient services and which may directly compete with private physicians.

The resolution was referred to the MSMS/HMSS Governing Council. The premise of this resolution is that not-for-profit hospitals have expanded their activities into areas which often compete directly with physicians (who do not enjoy tax-exempt status), thereby creating an uneven playing field.

MSMS Legal Counsel advises that even though an entity enjoys tax exempt status, income which is not related to its tax exempt purpose is subject to tax ("UBIT"). See Sec. 511 of the Internal Revenue Code ("IRC"). Section 513 excludes from the definition of UBIT activities carried on "primarily for the convenience of [the organization's]...patients." In Revenue Ruling 68-376, 1968-2 CB 246, the Internal Revenue Service purposes of the "convenience" exception. Specifically, that Ruling sets forth six situations in which a person would be deemed a patient and, therefore, the income earned from that activity would be tax exempt. Those six situations are:

A person admitted to the hospital as an inpatient.

5.

home care program; and

A person receiving general, diagnostic, therapeutic, or preventive health services from the outpatient facilities of the hospital;

A person directly referred to the hospital's outpatient facilities by 3. the person's private physician for specific diagnostic or treatment procedures.

A person refilling a prescription written during the course of the 4. person's treatment as a patient of the hospital; A person receiving medical services as part of a hospital-administered

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 A person receiving medical care and services from a hospital-affiliated extended care facility.

Upon a great deal of study, it was determined that the most effective reform

would have to be completed at the federal level.

However, MSMS is also conferring with legal counsel regarding appropriate legislation eliminating the tax exempt status for those for-profit entities associated with not-for-profit hospitals at the state level (i.e. property taxes and state income tax).

12-95A Title: Designation of Corporate Affiliated Physicians. Approved.

This resolution requested MSMS designate that all physicians heretofore known as "salaried physicians" or "employed physicians" carry the title Corporate Affiliated Physician(s) (CAPs). It also asked MSMS to seek to address the needs of the CAP(s) in their employment settings, as well as organized medicine and encourage membership of the CAP through program and activity development aimed at and specifically for the CAP interests. It also requested that MSMS maintain open dialogue and close relationship with those organizations which contract with CAP(s).

The MSMS Corporate Affiliated Physicians Committee formed a subcommittee on membership, which has identified over 600 physicians involved in medical practice meeting the definition of an employed/CAP physician. This ongoing effort is expected to bring about the identification of approximately 1,000 CAP physicians within the next year. A second subcommittee devised an "identification questionnaire," which was mailed to identified CAP physicians with a 32 percent returned. This strong response has caused the Committee to develop in conjunction with MSU School of Labor and Industrial Relations colloquies which will be presented during the Summer and Fall 1996. A Fall 1996 business/education conference is being planned to provide in depth business and management information to be of use on a day to day basis by the CAP physician. These colloquies and business/education programs are being considered to become part of the MSMS Master Series Programs.

13-95A **Title: Michigan Patient Protection Act.** Referred to the Board for Study.

This resolution requests that MSMS include in the proposed Michigan Patient Protection Act, language as proposed by the National Access to Specialty Care Coalition.

This resolution was referred to the Board of Directors for further study. The Board of Directors then referred the resolution to the Michigan Patient Protection Act Task Force. The MPPA Task Force discussed this resolution in depth and recommended various portions of the recommendations be included in the Michigan Patient Bill of Rights. Due to the fact that the Michigan Patient Bill of Rights is an on-going developmental process, the MPPA Task Force agreed that the resolution be reviewed on a regular basis by the Task Force and continue

to recommend changes to the bills as needed.

House bills 5570-5574 (The Michigan Patient Bill of Rights), were introduced in early February, 1996. As introduced, the bills include provisions that would require insurance companies and managed care organizations to provide patients with upfront information regarding important information about their health plans; prohibit insurance companies and HMO's from excluding coverage based on pre-existing conditions if an individual has been enrolled in that plan for at least six months; requires insurance companies and managed care organizations to give physicians the opportunity to apply for participation on a health plan panel and if that individual is denied access, the health plan is responsible for explaining to that physician why they were not included on the health plan panel; and would indemnify the physician if appropriate care was denied by a health plan against the wishes of that treating physician. Additional patient bill of rights legislation is expected to be made a part of this important package. MSMS has organized a strong coalition of patient and provider organizations called the Michigan Partners for Patient Advocacy, in order to seek passage of this important legislation.

14-95A Title: Model State Legislation Against Arbitrary Denial or Termination of Medical Staff Privileges. Adopted as Amended.

This resolution requested that MSMS seek legislation to provide protection for existing medical staff members against arbitrary denial or termination of medical staff privileges and that MSMS seek legislation that recognizes hospital medical staff bylaws as a contract that affords due process to all members of the medical staff.

The resolution was referred to the MSMS/HMSS Governing Council which researched this matter. The resolution was forwarded to the Michigan Health and Hospital Association where it was reviewed by its Council of Physicians.

The Council of Physicians believes that legal protection does exist to protect

medical staff applicants and existing medical staff members against arbitrary decision making. This protection can be achieved through local solutions in the drafting of medical staff bylaws approved by the hospital board. The JCAHO provides standards that outline many of these protective provisions (see 1996 Comprehensive Accreditation Manual for Hospitals, Section 3, "Organization, Bylaws, Rules and Regulations.")

MSMS leadership and legal counsel has continued to review this issue. MSMS has filed an amicus curiae brief supporting the hospital medical staff of the Macomb Hospital Center in urging the Supreme Court to recognize hospital medical staff bylaws as a contract that affords due process to all members of the medical staff. As this issue moves through the court process, MSMS has invested a great deal of resources in this issue and has not found it timely to seek legislation. However, MSMS intends to seek legislation at the appropriate time.

15-95A Title: Hospital Networks. Adopted as Amended.

This resolution requested that MSMS support the concept that consolidation of medical staffs or departments and associated bylaws and department policies and procedures must require the approval of all medical staffs and/or departments so involved.

The resolution was referred to the MSMS/HMSS Governing Council which in turn communicated the resolution and its recommendations to the Michigan Health and Hospital Association where it was reviewed by its Council of Physicians.

The Council of Physicians believes while the involvement of the medical staff in decisions regarding departmental consolidation may be beneficial, there may be instances where administrative staff, as the agents of the board (which holds the fiduciary accountability for the institution), may be forced to take actions that do not meet with the approval of the medical staff. Again, the MHA can support the concept that hospital administration should seek to involve physicians at every possible opportunity, but the association cannot in this instance intervene with respect to their decision-making authority. Council research has determined that provisions currently exist in the JCAHO Manual, section MS 2.3.6.1, that there be "an established mechanism for the medical staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the hospital."

16-95A Title: Medicare Revised Implementation Instructions for Automated Laboratory Tests. Disapproved.

17-95A Title: Clinical Laboratory Improvement Act (CLIA) 88. Approved.

This resolution asked the AMA to support legislation proposed by the Specialty Care Coalition to amend the Clinical Laboratory Improvement Act Amendments of 1988 to exempt physician-office and other small laboratories.

MSMS wrote AMA Executive Vice President James S. Todd, MD, September 19, 1995, requesting AMA action on this resolution. Doctor Todd's response on November 1 was that the AMA was engaged in a fight to have this important reform enacted. He reported that a comprehensive U.S. House package of bills had just passed which exempted physician-office labs from the CLIA provisions. He was hopeful that the exemption would be included in a House-Senate Conference report and signed by the President into law.

18-95A **Title: Privacy and Confidentiality of Medical Records.** Substitute Resolution (in lieu of 18-95A and 99-95A). Adopted.

This resolution asked MSMS to review the current threat to privacy as to the confidentiality and security of the patient medical records and to take appropriate measurers to maintain the security of patient records.

The use of claims data to monitor utilization patterns and to determine the costs of care is now quite common among third party payers and employers. Patients sign a waiver that allows the insurance company to collect necessary data in order to pay claims. Putting the limitations of using claims data to measure health care utilization aside, use of this data in aggregate does not pose a threat to patient confidentiality. However, as this information is passed from one party to another for the purpose of processing and analyzing, it is important that all involved in handling the data implement appropriate safeguards and agree to be vigilant in protecting the information on individual patients.

Appropriate safeguards already exist in the Michigan Inpatient Database (MIDB), which assembles patient record abstracts from all hospitals in the state. One of the guiding principles of the group that has historically produced the database, the Michigan Health Data Corporation, has been the protection of individual patient data. Many research projects have been conducted using the MIDB, and all requests for data are reviewed for compliance to access

principles which protect against any individual patient data being released. This

system has worked very well in this regard.

A package of bills has been introduced to the Michigan legislature that would create a mandatory health data system. Although this system would be primarily interested in assessing the performance of physicians and hospitals, it would include the collection of patient information in order to do so. Although no immediate action is expected, MSMS is monitoring the progress of these bills and will work to ensure that language and protocols that protect individual patient data are included in any final version. This same standard of confidentiality will be applied to any other initiative that includes the collection or use of patient level data.

19-95A Title: Medical Staff Bylaws: A Contractual Relationship.

This resolution calls for MSMS to reaffirm its position that the hospital medical staff bylaws constitute a contract between a hospital and its medical staff and oppose any unilateral change of the hospital medical staff bylaws. It also asked that this matter continue to be brought to the attention of Michigan physicians and that MSMS commit the resources it believes necessary to support

This resolution was referred to the MSMS/HMSS Governing Council which monitored the Macomb Hospital Center Medical Staff, et al. vs. Detroit-Macomb Hospital Corporation Circuit Court suit. On December 27, 1994, the Macomb County Circuit Court judge granted the Hospital's motion to dismiss. The Court held that bylaws are essentially directed to the conduct of the Medical Staff and are not "contractual in nature." The Medical Staff requested that MSMS file an amicus curiae brief in support of the Medical Staff's appeal and argument that the bylaws create contractual rights. In May of 1995, MSMS filed "Brief Amicus Curiae of Michigan State Medical Society and the American Medical Association. The Medical Staff agreed to a conciliatory position offered by the Macomb Hospital Center Governing Body. The MSMS Board of Directors has determined to monitor this issue to ensure that MSMS policy is implemented. At this time, MSMS position is contrary to the opinion of the Macomb County Circuit Court and has made known to medical staffs they insist an article be included in their bylaws and those of the hospital governing body that medical staff bylaws constitute a contract.

The resolution was forwarded to the Michigan Health and Hospital Association where it was reviewed by its Council of Physicians. The MHA's position on the issue raised by this MSMS resolution (which calls for the recognition of hospital medical staff bylaws as a contract) has been well documented. The MHA continues to believe that the medical staff bylaws do

not constitute a contract.

Section MS 2.1 of the JCAHO Manual does state that "Medical staff bylaws...are adopted by the medical staff and approved by the governing body before becoming effective." This may be another issue where improved communications between all parties would be mutually beneficial, and MHA and MSMS may have a role in facilitating that communication, either through education programs, the creation of a dispute resolution mechanism, or other

The Council suggested that consideration be given to forming a "Joint Conference Committee" of MSMS, MAOPS, and MHA members to help

communicate and resolve such issues.

The third resolved of this resolution calls for continued publication in Medigram and Michigan Medicine of the fact that hospital staff bylaws constitute a contract. The publications both have continued their coverage throughout the year of the Detroit-Macomb Hospital medical staff's lawsuit which provoked this resolution. The AMA joined the lawsuit with creation of its new litigation center, whose executive committee chair is William E. Madigan. However, in late 1995, the attorney for the Macomb physicians bringing the lawsuit exerted pressure on the physicians to drop their case. The MSMS brief filed March 6, 1995, is still pending with the Court of Appeals and MSMS continues to hold its supplemental brief pending a determination on the status of the case. Publications will continue to emphasize that medical staffs regard bylaws as a contract and that the bylaws should be treated as such.

Title: Expand Promotion of the Michigan Professional Credentials Verification Service (MPCVS). Approved.

This resolution called for MSMS to continue support of the Michigan Professional Credentials Verification Service (MPCVS) and to encourage physicians to use the MPCVS by advertising its potential for reducing the number of forms required for physicians to apply for hospital privileges, health plan participation and malpractice insurance.

This resolution also asked MSMS and the Michigan Health and Hospital Association to work together to promote the MPCVS to IMGs and Liaison Committee on Medical Education (LCMEs) for use when applying for managed care plans, hospital staff credentialling, county and state medical society

The Michigan State Medical Society and the Michigan Health and Hospital Association, partners in the Michigan Professional Credential Verification Service, have entered into full operation. Twenty health care entities have submitted 265 applications for initial medical staff privileges for primary source credential verification. The response of entities that have received verification packets has been very favorable as to the quality and comprehensive scope of verification.

The mission of MPCVS is to focus on the formation of a centralized data storage facility to provide primary source verification of the credentials of physicians and allied health professionals in compliance with accreditation standards of the Joint Commission of the Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance

(NCQA).

Marketing efforts reflect the quality of the services to be provided with an emphasis on the unique characteristics of MPCVS as a verification service.

Marketing and promotional efforts have been intensified to managed care organizations. Educational materials and meetings with physicians, medical staff personnel and administrators are a priority marketing effort. The use of the MPCVS services by physicians and managed care industry in Michigan is critical to the objective of converting MPCVS from an effective vendor of credentials verification services to a true credential verification organization.

A marketing out-reach through expanded activity of the MPCVS director and augmented by additional marketing assistance that MSMS and MHHA may be willing to provide. MSMS has offered to provide MPCVS staff support

to assist in the implementation of intensified marketing activity.

The relocation of MPCVS to MSMS contributes to improved coordination of the Service with the Physician's Review Organization of Michigan (PROM) in responding to requests from managed care organizations to provide a complete NCQA credentialing and office audit program. These managed care organizations are seeking a coordinated source for these two services.

Through the formation of MPCVS, MSMS and MHHA have recognized the importance of the credentials verification process to the delivery of quality health care services to the citizens of Michigan. The joint effort is focusing on gaining participation of managed care hospitals and other entities requiring verification to reduce the hassle of multiple forms.

21-95A Title: Reporting of Malpractice Information in the National Practitioner Data Bank. Approved.

This resolution asks the AMA to review the appropriateness of the National Practitioners Data Bank practice to include the malpractice history of physicians in training, even though the activity was performed within the parameters of the physicians' supervised training.

The Michigan Delegation to the AMA forwarded this resolution to the 1995 Interim Meeting of the AMA. The AMA House of Delegates adopted a substitute resolution which asked the AMA to reaffirm that the AMA believes the NPDB should be dissolved, and calling for the AMA Board to report back to the AMA House on progress in June 1996.

Title: Visa Status Changes for International Medical Graduates (IMGs). Adopted as Amended.

This resolution called for MSMS to strongly oppose the proposed change in the Immigration and Naturalization Service rules requiring a foreign medical graduate who is currently in H-1B status to seek a change of status to that of a J-1 non-immigrant to remain a resident physician in graduate medical education in the United States.

This resolution was forwarded to the AMA House of Delegates for consideration, where it was referred to the AMA Board of Trustees for further study. The reason for the referral, according to the AMA; "the issue of visa status is complex. While the circumstances prompting the introduction of this resolution refer only to the specific group of individuals, the issue of the visa status of trainees is a broader one which requires analysis and clarification."

Title: Discrimination Against International Medical Graduates (IMGs). Adopted as Amended.

This resolution asked the AMA to present appropriate regulatory agencies with letters suggesting that certain residency programs have refused to consider an applicant based on graduation from an international medical school, and to notify all graduate medical education programs of the AMA policy on physician discrimination.

Michigan Delegation Chair Billy Ben Baumann, MD, forwarded this Continued on page 49

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Speaker's Report (continued)

resolution by letter to James S. Todd, MD, AMA EVP, in September. Doctor Todd replied in November that the AMA's Advisory Committee on IMGs had recently begun working with the AMA Division of Graduate Medical Education to investigate the issue. They were considering several avenues, including contacting the Secretary of HHS regarding Title VII financing. Doctor Todd was asking the Advisory Committee to review the MSMS resolution before considering final action. He also said the Advisory Committee was considering notifying GME programs of AMA policy.

Title: A Nationwide International Medical Graduate (IMG) Newsletter Published by the AMA. Adopted as Amended.

The resolution asked the Michigan Delegation to the AMA to urge the AMA to publish information or a newsletter focusing on IMG issues, which

would go to all IMGs, AMA members and non-members.

This resolution was forwarded to the 1995 AMA Interim Meeting, where a substitute called for the AMA to use existing mechanisms, as well as future electronic mechanisms, to communicate information of particular information to its various demographic groups.

Title: Safeguarding Fairness of Educational Commission for 25-95A Foreign Medical Graduates (ECFMG) New Test of Clinical Competence. Approved.

This resolution asked the Michigan Delegation to the AMA to ask the AMA to ensure that the ECFMG New Test of Clinical Competence based on the examination of live patients be administered consistently between all test locations, to monitor the fairness of this clinical testing process, and for the Delegation to report back to the MSMS IMG Section.

The Delegation forwarded this resolution to the 1995 AMA Interim

Meeting, where it was not adopted.

Title: Resolution to Seek Amendment to the Public Health Code. 26-95A Substitute Resolution (in lieu of 5-95A, 26-96A and 78-95A). Adopted. See Resolution 5-96A.

Title: Women's Choice of Health Care Provider. Adopted as 27-95A

This resolution requested that MSMS seek legislation that would designate the obstetrician/gynecologist as a primary care physician and to allow women

access to the primary care provider of their choice.

MSMS has worked closely with the Michigan Section of the American College of Obstetricians and Gynecologists, and the Michigan Council for Maternal and Child Health in order to seek appropriate legislation. MSMS has worked with Representative Lyn Bankes in order to draft legislation that would designate the obstetrician/gynecologist as a primary care physician and require insurance companies and managed care organizations to recognize that designation. MSMS, MS-ACOG, and The Michigan Council for Maternal and Child Health, have met with Representative Bankes regarding this legislation on various occasions. The bills have been drafted and are expected to be introduced relatively soon after appropriate changes have been made. MSMS will continue to work with appropriate organizations and lawmakers in order to seek this legislation.

Title: Health Plan Performance. Substitute Resolution (in lieu of 28-95A 28-95A and 97-95A). Adopted.

The resolution called for MSMS development of a system to evaluate health

plan performance.

In September, MSMS invited all Michigan health plans to participate in our effort to review policies and practices. Information from the plans, together with information from state regulatory filings was compiled to produce information on financial issues, quality, administrative efficiency, utilization management and benefit considerations. As requested by the resolution, the evaluation includes a complete financial analysis, detailing proportions of premium spent on administration and health expenses.

MSMS released the evaluation on March 21. Nearly 200 physicians, business representatives, patient advocates, health care associations, media representatives and policymakers attended meetings on March 21 to learn about our efforts. Since release of the evaluation, several health plans have offered to participate with us in future evaluations. Individual plan information will be updated on an ongoing basis, with summary reports updated and released annually. This has been an extremely positive project for MSMS, providing needed information to members and attracting attention from many statewide groups.

Title: Term Limits for Michigan Delegation to the AMA. 29-95A Disapproved.

Title: MSMS Financial Reports. Adopted as Amended. 30-95A

This resolution asked the MSMS Treasurer to develop an annual financial report for the House and Delegates and for MSMS to print the financial report in Michigan Medicine.

The Finance Department under the direction of Treasurer Billy Ben Baumann, MD and Executive Director William E. Madigan assembled a financial report on the past and future planning structure of MSMS. This report will be the base of an annual financial report that will be presented to the House of Delegates. We will focus on the prior years audit report and the current years Operating Fund Budget.

Annually Michigan Medicine will print a summary of the annual audit. This

summary will appear in late spring or summer.

Title: Congressional Cuts on Student Loans. Approved.

This resolution called on MSMS to work with the medical students, residents and young physicians while developing information on the effect of discussed budget reductions of medical school student loans. MSMS was also asked to disseminate the information by FAX, electronic mail or Western Union when

Since the 1995 MSMS House of Delegates the MSMS Committee on Federal Legislation has met twice and followed the issue continuously while gathering essential information in conjunction with the AMA. Congressional representatives were contacted by letter in June, regarding the serious implications of the proposed budget cuts which include the increased debt load for medical students, the effect on specialty choice as well as any decision regarding location of practice. The effect could have been devastating for medical care in rural areas.

MSMS also met on two occasions with the following representatives from the Michigan Congressional Delegation, Congressman: James Barcia; Dave Camp; Dick Chrysler; Dale Kildee; Joe Knollenberg; Bart Stupek and Senators Carl Levin and Spencer Abraham. MSMS physicians also met with many of the Congressional representatives in March. This information has been

published in all MSMS publications.

The student loan provisions remain a part of the Budget Reconciliation legislation currently stalled in Congress. However, over the past year MSMS and the AMA have seen a successful reverse of Congressional opinion in favor of student interests and remain optimistic that the favorable student loan provisions will persevere. Both MSMS and the AMA will continue to monitor this issue closely.

Title: Letters to Congressional Leaders from Patients. Adopted 32-95A as Amended.

This resolution requested that MSMS provide physician members, upon request, with clearly written model letters and/or basic information such as bill numbers and key elements for patients' use in writing to policy makers about key health care legislative and regulatory matters occurring in the future.

MSMS has implemented a strong policy to provide physician members with all appropriate and necessary, clearly written, information regarding legislation and regulatory matters. This includes summaries of the legislation, background information and appropriate actions to be taken with specific guidance in taking those actions. In addition, MSMS continues to expand the Physician Legislative Network (PLN), which now includes approximately 4000 members who receive regular updates regarding the most pertinent legislation. In many cases PLN members are faxed legislative alerts with specific background and calls to action. MSMS also develops brochures, posters, and other communications tools for physicians' use for providing information to their patients and to their colleagues. MSMS also provides excellent coverage of legislative and public policy matters through Medigram and Michigan Medicine. MSMS will continue its commitment to providing the best and most pertinent information to MSMS members.

Title: Stark II Information. Adopted as Amended.

This resolution requested that MSMS develop a seminar and/or means of disseminating information concerning Stark II legislation and recent

Consolidated Omnibus Budget Reconciliation Act changes.

MSMS legal counsel has made presentations to several county medical society meetings, developed articles for Michigan Medicine, and provided information upon request to county medical societies concerning the issues raised by this resolution.

34-95A Title: MSMS Practice Management Resources. Approved.

This resolution requested that practice management information be put on line to allow members easy access to office management assistance.

MSMS regularly publishes information through its publications on reimbursement, risk management and office management issues. As MSMSNET - our on line service for members - continues to improve and expand its content, these articles are featured on our home page. During 1996, MSMS plans to offer real time "chat sessions" with MSMS staff resource persons in all areas of office management. In the meantime, these resource persons are identified on the email address list featured on the MSMS home page, giving members easy access to staff experts who can answer their questions about office management issues.

35-95A Title: Provide Transportation for the Alcohol Impaired Driver. Adopted as Amended.

This resolution asked MSMS to work with local governments, community organizations and business coalitions to promote on a year round basis safe transportation home for intoxicated persons.

MSMS is working with community organizations and local businesses to provide safe transportation home for intoxicated persons on a year round basis.

Senate Bill 641, which would reduce the blood alcohol content for operating a motor vehicle under the influence or operating while visibly impaired was introduced in September 1995 and is currently pending in the Senate Committee on Judiciary.

Senate Bill 469, which provides mandatory warnings regarding use of alcohol during pregnancy on liquor advertising inside licensed premises, was introduced April 1995 and is currently pending in the Senate Committee on Health Policy and Senior Citizens.

MSMS will continue to work with the state legislature and other community organizations to introduce and support legislation that would lower drunk driving in Michigan.

36-95A Title: Genetic Screening Affecting Insurance Policy Rates. Adopted as Amended.

This resolution requested that MSMS support legislation that would prohibit the health insurance industry from basing coverage and rates on the knowledge of genetic risk.

House Bill 5237 was recently introduced by Representative Mike Bennane (D-Detroit), Representative Laura Baird (D-East Lansing) and Representative David Anthony (D-Escanaba). This bill prohibits using genetic tests to determine insurability and was referred to the House Committee on Insurance. The MSMS Committee on State Legislation and Regulations recently discussed this legislation and expressed their strong support. MSMS finds this legislation to be increasingly important as genetic testing becomes more advanced. MSMS will continue to seek passage of this legislation.

37-95A Title: Controversial Cable Television Programming. Adopted as

This resolution directed the Michigan Delegation to ask the AMA to explore mechanisms by which parents may gain greater control of home access to controversial cable television programming.

The resolution was introduced at the 1995 Interim AMA Meeting, where it was adopted.

38-95A Title: Optometrists: The Responsibility of the Practice of Medicine. Referred to the Board for Study.

This resolution requested MSMS to work with the Board of Optometry and other appropriate bodies to formulate educational requirements regarding the specific use of ocular therapeutic pharmaceutical agents and that MSMS seek legislation requiring optometrists to attend appropriate medical education courses.

The Committee on State Legislation and Regulations discussed this resolution in great detail. Members of the Committee agreed that the practice of optometry needed to be monitored on a continuous basis and legislation should be introduced to ensure that optometrists stay within their scope of practice and are properly monitored. However, Committee members could not agree on exactly how that would be done. Therefore, the Committee on State Legislation and Regulations created a subcommittee that was charged with drafting a recommendation and reporting directly to the Board of Directors.

The MSMS Subcommittee on Optometry Scope of Practice, met via telephone conference call on February 8, 1996. Those participating were Mark D. Kolins, MD, Chair; Patrick Droste, MD; Paul Fecko, MD; Carol Krieg, MD;

Michael Sandler, MD; Max Walsh, MD; Joseph Wilhelm, MD; George Williams, MD; Greg Aronin, MSMS Staff; Richard D. Weber, MSMS Legal Counsel and Andrew Lott, MOS Staff.

Subcommittee members discussed the fact that continuing education units are included in the proposed rules that require optometrists complying with the new scope of practice law to increase their educational standards. While most members did not believe that the continuing education requirements were sufficient, they stated that their charge is to develop the most appropriate policy for MSMS and the Michigan Ophthalmological (MOS). While some members believe that MSMS and MOS should move forward with legislation further monitoring the practice of optometry or further reducing the optometry scope of practice, other members expressed their concern that the introduction of legislation could result in amendments that would further expand optometry scope of practice.

Upon further discussion, members agreed that the best strategy would be to prevent optometrists from further expanding their scope of practice and to limit the practice of ophthalmic medicine to ophthalmologists.

The Subcommittee voted to recommend that MSMS work with the Michigan Ophthalmological Society to limit the practice of ophthalmic medicine to ophthalmologists and support legislation and efforts to achieve this goal.

39-95A Title: Blood Alcohol Levels. No Action.

40-95A Title: Designated Driver Promotion. Approved.

This resolution requests that MSMS seek legislation to encourage establishments serving alcohol to promote identification of a designated driver and that MSMS seek legislation requiring alcohol related advertisements to promote the concept of a designated driver.

MSMS has discussed this issue with various lawmakers and has expressed its concern with regard to the public health and safety of Michigan citizens due to the problem of driving under the influence. SB 665 has been introduced in the Senate indirectly related to this matter, which would give physicians the authority to contact the appropriate authorities when they believe an individual is not fit to drive. MSMS has also worked with lawmakers to pass legislation which would require bars, restaurants and stores that serve alcohol, to post signs informing individuals of the dangers of fetal alcohol syndrome and fetal alcohol effects. MSMS will continue its efforts regarding this matter.

41-95A Title: Procedures of MSMS House of Delegates. Adopted as Amended.

This resolution calls for the MSMS Bylaws, Section 13.70, titled Rules of Order, to be amended to read "When not in conflict with the Constitution or Bylaws of this Society, Davis Rules of Order shall govern the parliamentary procedure of the House of Delegates.

This amendment would mean a change in procedures from Roberts Rules of Order to Davis Rules of Order, which are utilized at the AMA meetings. There was a great deal of support for this change which will help move along the House of Delegates proceedings in a more efficient manner. The resolution was adopted on first reading at the 1995 House of Delegates and is on the agenda of the Constitution and Bylaws Committee to be submitted for final reading at the 1996 House of Delegates Meeting.

42-95A Title: First Aid and Cardio-Pulmonary Resuscitation (CPR). No Action.

43-95A Title: Repeal the Internal Revenue Service (IRS) Excise Tax on Immunization Stocks. Approved.

This resolution directed the Michigan Delegation the AMA to request the AMA to seek elimination of the excise tax on immunization stocks.

The Delegation forwarded the resolution to the 1995 AMA Annual Meeting, where the AMA House adopted an amended resolution to call on the AMA to study the implications of repealing the excise tax.

44-95A Title: Medicaid Managed Care for Mental Health. Approved.

This resolution asked MSMS to work with the Michigan Department of Social Services to completely revamp its Medicaid Mental Health Managed Care Program, using more realistic issues including substance abuse and maintaining doctor/patient relationships which currently exist and to urge the Michigan Department of Social Services and the Michigan Department of Mental Health to work with MSMS and the Michigan Psychiatric Society to draft the Medicaid Mental Health Managed Care Program prior to

implementation.

Members of MSMS and MPS initiated a meeting with James Haveman. Director, Michigan Department of Mental Health and Vernon Smith, PhD, Director, Division of Medicaid, Department of Social Services to voice our

concerns regarding the proposed change.

The following individuals were present at the meeting with Directors Haveman and Smith: Linda Hryhorczuk, MD, President MPS; V.P. Veluswamy, MD, Director Psychiatric Services Oakland County Community Mental Health Services; Michael Szymanski, MD, President, MAFP; Gregory Aronin, MSMS Staff; and Christine Shearer, MSMS Staff.

The Michigan Department of Mental Health took our concerns into consideration. MSMS will continue to monitor the Medicaid Managed Care for Mental Health Program and the effects it has on patients quality of care.

45-95A Title: Physicians Sponsored Plan (PSP) Assignment of Pediatric Cases. Adopted.

This resolution requested that MSMS procure a commitment from the Michigan Department of Social Services to involve pediatricians who wish to be involved in the random assignment of pediatric patients and to aggressively pursue with the Michigan Department of Social Services the establishment of a local physician oversight committee for the Physician Sponsor Plan.

MSMS continues to work with Vernon Smith PhD, Director, Division of Medicaid and his staff to involve pediatricians who wish to be involved in the random assignment of pediatric patients. Currently Medicaid's computer system can not identify a patients age or date of birth. However, they project its

completion by July of 1996.

Title: Motor Vehicle and Bicycle Safety. Adopted as Amended.

This resolution asked MSMS to support legislation that would make safety belts non-use of any occupants in automobiles and other enclosed motor vehicles a primary offense and that MSMS support existing legislation that requires helmet usage among riders of motorcycles of all ages and that MSMS support extension of the motorcycle helmet law to all age groups to include other twowheel motorized vehicles such as mopeds and that MSMS support legislation that would require helmet usage for riders of bicycles, including passengers.

HB 5000 introduced by Representative Frank Fitzgerald, would make the violation of the current safety belt use law a primary offense. This legislation which is being supported by MSMS, the Michigan Department of Public Health, the Michigan Department of Transportation, the Michigan State Police, the Michigan Association of Osteopathic Physicians and Surgeons, the Michigan College of Emergency Physicians, various auto insurance companies, and General Motors, Ford and Chrysler, has been reported out of the House Transportation Committee and is expected to be voted upon on the House floor. MSMS has engaged in a lobbying effort in order to pass this legislation and encouraged members to contact their lawmakers to express their support of this important legislation.

MSMS strongly opposed legislation that would eliminate the existing law requiring helmet usage among riders of motorcycles of all age groups. Due to the efforts of MSMS and other organizations, this legislation was defeated on

the House floor by a relatively significant margin.

In 1995 MSMS supported legislation introduced by Senator George Hart (D-Dearborn), that extends the motorcycle helmet law to other two-wheel motorized vehicles such as mopeds. The legislation also extended the helmet law to child bicycle riders. This legislation underwent various committee hearings. Although the bill had a great deal of support, it did not pass before the end of the 1995 portion of session. MSMS is currently seeking this type of legislation in the 1996 portion of the session. MSMS will continue to advocate for these important public safety issues.

The Michigan Delegation to the AMA asked the AMA to introduce a battery of requests supporting legislation making safety belt non-use by auto occupants a primary offense, requiring helmet usage by all motorcyclists, extending the motorcycle law to all other two-wheeled vehicles, and requiring helmet use by all bicycle riders. This resolution passed the 1995 AMA Annual

Meeting with minor amendments.

47-95A Title: Assistive Technology for Disabled Patients. Adopted as Amended.

This resolution asked MSMS to urge appropriate state agencies to communicate with physicians on how to access assistive technology for their patients.

MSMS will continue to work with Michigan's Assistive Technology Project (TECH 2000) to increase awareness of assistive technology for all Michigan citizens, and to promote ready access to assistive technology devices, services, and funding sources for all individuals with disabilities anywhere in the state through changing the way the system works. Informational booklets regarding how to access assistive technology services, funding and devices will be made available to Michigan physicians through Tech 2000.

The second Resolved of this resolution called on MSMS to ask the AMA to support funding of the amended Technology Act of 1988 at the federal level to begin provision of assistive technology to disabled persons in each state. The Michigan delegation introduced this resolution at the 1995 Interim Meeting. The AMA House referred this resolution to the Board of Trustees for report back to the 1996 AMA Annual Meeting.

48-95A Title: Omnibus Budget Reconciliation Act (OBRA) Screening: Improving Efficiency. Referred to the Board for Study.

This resolution requested MSMS to work with the Michigan Department of Mental Health to ensure that Calhoun County physicians, the Battle Creek Health System, and Calhoun County Mental Health receive seven days a week coverage from the Michigan Department of Mental Health for clearance of the mental health screening process.

This resolution was referred by the Board to the Mental Health Liaison Committee which reviewed the resolution at their February 14, 1996 meeting. The Committee voted to support this resolution by amending it allow the Department of Mental Health a maximum response time of 3 hours be mandated

statewide.

Title: Role of Medicare Carrier Medical Directors in the Resource 49-95A Based Relative Value Scale (RBRVS). Approved.

This resolution asked the Michigan Delegation to the AMA to ask the AMA to strongly urge HCFA to require Medicare carrier medical directors to adopt a review process as rigorous and comprehensive as that used by the Relative Value Update Committee, before they alter the RUC's recommendations for relative work values for CPT-4 codes now or in the future.

The Delegation introduced the resolution at the 1995 AMA Annual Meeting, where it was combined with another resolution and a Board report, and a substitute passed. This new resolution directs the AMA to provide assistance to state and county medical societies, specialty societies and medical groups, to assure that implementation of Medicare RBRVS payments by Carrier medical directors is done appropriately, and that the design and implementation of RBRVS-based payment systems by all third party payers is consistent with the intentions of the AMA/Specialty Society RVS Update Committee.

Title: Ability Based Criteria for Physicians to Participate as Providers in Health Insurance Programs. Referred to the Board

This resolution asked MSMS to work with the insurance commissioner to enact rules which would prohibit health insurance companies from using factors unrelated to a physician's ability and training in evaluating the physician for inclusion as a member of their panel of physicians.

MSMS held its first Liaison Committee meeting with the Insurance Bureau on January 30, 1996. Committee members voiced their concerns regarding health insurance companies using unrelated factors in evaluating a physician's training and ability. MSMS will continue to work through the Insurance Bureau

Liaison Committee regarding this issue.

MSMS has been working with Representative John Jamian in developing legislation that would mandate Insurance companies and managed care organizations to base their evaluation of health care providers on quality of care delivered and professional competency and not unrelated economic criteria.

Title: Evaluation of Food and Drug Administration (FDA) Regulations. Approved.

This resolution asked the Michigan Delegation to the AMA to ask the AMA to investigate costs and public effects of current FDA policies for approving new drugs and medical devices and to request the FDA to continue safety requirements but to require proof of a highly-probable efficacy rather than the absolute proof now required. The resolution notes that physicians can determine the ultimate efficacy of a medication or device.

The Michigan Delegation forwarded this resolution to the June 1995 AMA Annual Meeting. The AMA House considered this resolution and three others with a Board report, which the reference committee rewrote and the House then adopted in lieu of two of the resolutions. The House referred the Michigan resolution and one other to the Board. The AMA House reaffirmed policy to monitor and respond to FDA changes, as well as legislation affecting the FDA, reaffirmed its support of an adequate budget for the FDA, and directed that the AMA continue to work with the FDA on controversial issues to resolve

physician concerns and to support FDA initiatives of potential benefit to patients and physicians.

Title: Smoke Free Public Areas. No Action. 52-95A

Title: Commendations to Delta and Northwest Airlines. 53-95A Approved.

This resolution asked the Michigan Delegation to the AMA to ask the AMA to commend Northwest and Delta airlines for their no smoking policies during flights, and encouraging them to expand the policies to include all flights departing from or arriving at American airports. Michigan Delegation Chair Billy Ben Baumann, MD, forwarded these MSMS requests to AMA EVP Jim Todd by letter. Doctor Todd subsequently promised, in a letter, that the AMA would write the airlines. He also noted that the AMA has championed the effort to eliminate smoking in our society and has consistently stressed the need to eliminate all smoking on airlines. AMA activities include liaison with the World Medical Association and the International Civil Aviation Organization, he noted. He said that through these organizations the AMA will work to mandate that planes arriving or department from American airports be smoke-free.

Title: Smoke Free Restaurants. No Action. 54-95A

Title: Presidential Rotation. Referred to the Board for Study. 55-95A

This resolution asked MSMS to change the rotation of the MSMS presidency between Outstate and Wayne County to 3:1 with the presidency to be slotted to a Wayne County member in the year of a national presidential election.

The Presidential Rotation Task Force developed three recommendations pursuant to Resolution 55-95A.

The first recommendation is that Wayne County Medical Society be given the opportunity to increase its membership to a minimum of 30 percent with a goal of 33 percent by December 1, 1997. If the 30 percent goal is not achieved, Resolution 55-95A will go into effect as of that date.

The second recommendation is that the Presidential Rotation Task Force meet again after December 1, 1997 to review membership numbers.

The third recommendation is that if Resolution 55-95A does go into effect, that it not follow the national presidential cycle as stated in the original resolution.

Title: Inspection of Restaurants. Substitute Resolution. Referred 56-95A to the Board for Study.

This resolution asked MSMS to request physician involvement in the Michigan Department of Public Health Blue Ribbon Food Service Advisory Committee's new process for restaurant inspection and encourage them to include a grading system with a requirement of posting a health inspection grade as part of the revised plan.

This resolution was referred by the Board to the MSMS Liaison Committee with Michigan Department of Public Health which reviewed the resolution at their January 10, 1996 meeting. The Committee voted to appoint Robert S. Levine, MD as the MSMS representative to the Michigan Department of Public Health Blue Ribbon Food Service Advisory Committee.

MSMS has recently been informed that all future meetings of the Blue Ribbon Food Service Sanitation Advisory Committee have been put on hold due to the Governor's Executive Order combining the Department of Public Health, Mental Health and Medicaid. MSMS will continue to monitor the progress of this task force.

Title: Frequency of Disability Certification Reports. Approved. 57-95A

This resolution requested MSMS to ask the insurance commissioner to issue guidelines that would limit health insurance carriers from asking for disability certification for acute illness and injuries no more frequently than for the lesser of the following time spans; 10 every 120 days; 20 physician's estimated length of disability, and to issue guidelines that would limit health insurance carriers from asking for disability certification for chronic illness no more frequently than every 12 months.

MSMS has been working with Representative John Jamian in developing legislation that would prohibit insurance companies and managed care organizations from refusing coverage based on preexisting conditions if a person has been enrolled in a plan for at least six months or has had coverage for that condition under their previous plan.

Title: Cost Notification. Adopted as Amended. 58-95A

The resolution requested that MSMS work with third party payers to improve physician awareness of the cost of services that they are asked to approve. including home health, durable medical equipment and physical therapy.

Increasingly, the issues addressed by this resolution are being provided through specific contracted providers designated by the insurer. In many instances though, physicians and their patients may have more discretion and cost considerations that are important. MSMS shared this resolution with several payers, who have indicated their interest in incorporating cost information through profiling and other feedback tools, physician newsletters and manual updates.

The resolution also requested that MSMS seek legislation that would require providers needing a physician's approval for their service or product, be required to provide the physician at the time of requesting the physician's approval, a cost estimate of services the physician is being asked to approve.

The MPPA Task Force continues to consider seeking legislation regarding a

cost estimate of services physicians are being asked to approve.

Indirectly related to this resolution, MSMS has been successful in introducing the Michigan Patient Bill of Rights, which among other things, requires insurance companies and managed care organizations, to provide potential enrollees upfront information regarding details of the coverage of the health plan, prior authorization requirements, and other pertinent information regarding the health plan. This legislation would require health plans to provide this information in a clearly written, understandable fashion. MSMS has expressed the importance of patients understanding all pertinent aspects of their health plan in order to make informed decisions about their health care. MSMS will continue to seek passage of this important legislation.

Title: Spouse Abuse: A Medical Problem. Adopted as Amended.

This resolution asked that MSMS work with the Michigan Department of Mental Health and the Michigan Department of Social Services to develop programs to prevent spouse abuse and to treat the spouse abuser.

MSMS will continue to work with the newly restructured and renamed, Department of Community Health to develop programs to prevent spouse abuse

and to treat the spouse abuser.

Governor Engler has issued executive orders to merge the departments of Public Health and Mental Health into a new Michigan Department of Community Health (MDCH), and he will transfer the state Medicaid program to the new department administration.

Title: No Fault Health Insurance. Adopted as Amended.

This resolution requested that MSMS seek legislation that would require that primary health insurance cover the cost of treatment for illness or injury until the responsible payor is identified in order to ensure continuity of care.

In order to properly address this and other insurance related issues, MSMS has established a liaison committee with the Michigan Insurance Bureau. At the first meeting of this liaison committee, members discussed the problems related to auto insurance company practices as they relate to physician reimbursement and situations detrimental to continuity of care. The Liaison Committee with the Insurance Bureau, will continue to work with the Insurance Commissioner and his staff, to address this and other important insurance related issues. MSMS will also seek the appropriate legislation to address this issue.

Title: Safeguarding Our Public Roads. Substitute Resolution (in lieu of 61-95A and 62-95A). Adopted.

MSMS was asked to study the issue of driver eligibility of age specific and disability specific situations, and present the information to the 1996 MSMS House of Delegates for their deliberation.

The Committee on Aging conducted discussions during several meetings regarding the older driver among its members and with representatives from the Office of Services to the Aging (OSA) and American Association for Retired Persons (AARP). A subcommittee reviewed selected articles from an extensive list developed through computerized search of a variety of data sources. The subcommittee received several cautions from OSA pointing out, it has been determined that current guidelines and policies for evaluating the older driver are arbitrary, inconsistent and could be considered a violation of the patients civil rights, and also a matter of age discrimination. Cautions were also received which identified the reporting systems as violating the code of confidentiality between the patient and the physician. The Committee became aware that the development of guidelines would be a costly project involving national experts on the older driver and driving safety, plus representatives from the American Association of Retired Persons, secretary of states office, senior citizens legal counsel and panel of geriatrist.

The Committee reviewed the 55 Alive program sponsored and conducted

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Speaker's Report (continued)

by AARP and identified several Michigan experts on the subject of the older driver and highway safety.

- 62-95A Title: Safeguarding our Public Roads (Drivers 16-19 Years Old). Substitute Resolution (in lieu of 61-95A and 62-95A). Adopted. See Resolution 61-95A.
- 63-95A Title: Citizen's Guide for Filing a Complaint. Disapproved.

64-95A Title: MSMS Restructuring. Referred to the Board for Study.

This resolution asked the MSMS Board of Directors to establish a task force to look at the organizational structure of MSMS, including its relationship to the county organizations and report back in two years (with an interim report in one year) to the House of Delegates on proposed changes that could streamline and increase the effectiveness of the organization.

This resolution called for a standing committee or task force to do what already is being done continuously by the MSMS Strategic Planning Committee, MSMS officers, various MSMS committees and senior staff. It is the opinion of the Strategic Planning Committee and the MSMS Board of Directors that it

would be redundant to act on these resolutions individually.

The Strategic Planning Committee formally meets each one to two years to update the three-year strategic plan with American Medical Association strategic planner, Bruce Balfe. Mr. Balfe takes the Committee through a detailed discussion of the current "environment," the achievements since the last plan was developed and implemented and a detailed discussion and analysis of what the Committee believes to be the most important activities and directions for MSMS for the next several years. A written document is prepared by Mr. Balfe and distributed to leadership and senior staff and is available upon request by individual members. Highlights are presented in Medigram and Michigan Medicine.

For example, at the most recent Strategic Planning Committee meeting on September 19, 1995, the "must do" list for 1996 included increasing young physician membership, impacting the Supreme Court races to help uphold our 1993 tort reforms, increased growth in electronic capability, providing support for physicians organizations and further increasing non-dues income (to help ensure an eighth year without a dues increase).

The future planning process at MSMS, however, is not a once-everyyear-or-two event. MSMS officers and senior staff work together daily to assess the health care environment, read the membership and make course changes to fulfill the "vision" of the organization. This is an effective process at MSMS that has been bred into leaders and senior staff for decades and has proven

again and again to be effective.

During the most recent year, MSMS leaders and staff have developed and expanded the MSMSNet (more than 10,000 "hits" so far); expanded the "Making the Rounds" program to visit 30 hospital medical staffs; started the Corporate-Affiliated Physicians Committee to respond to a growing area within our membership; joined with Michigan Physicians Mutual Liability Company to offer physicians "stop-loss" insurance for those working with capitated plans; plus many other forward-looking projects proposed and devised by leaders, staff and various committees and task forces.

A recent, potentially sweeping proposal from the Task Force on Physician Networks, for example, is for the establishment of an MSMS Physician Services Organization (PSO). As part of the initial research for this project, MSMS staff is conducting a series of nine focus group meetings with physicians from all over the state to take input and opinions. MSMS is also conducting detailed market research, site visits to other established PSOs and an analysis by legal counsel; all of which are standard operating procedures in an MSMS undertaking of this magnitude. Though the outcome is not yet defined, this is one more

example of the thorough planning processes utilized by MSMS.

MSMS senior staff also meet face-to-face with county medical society executive directors annually to discuss ways in which the symbiotic relationship between the entities can be enhanced. MSMS quarterly provides the counties with a guide to joining or enhancing on-going MSMS activities. MSMS also is connected with the counties through electronic mail and through the Internet. In an effort to reduce staff costs and improve collection efficiency, MSMS does the membership billing for all counties except Wayne County. MSMS staff also meets regularly with county membership committees to discuss ways to increase and maintain membership on the local level. MSMS also assists Oakland County and Muskegon County with staffing of the executive director and secretary, respectively. MSMS is always seeking ways to improve the communication and cooperation between MSMS and the county medical societies.

75A Title: Physician Liability Coverage for Mandatory Hospital Clinic and Emergency Department Coverage. Substitute Resolution (in lieu of 65-95A and 66-95A). Adopted.

This resolution called upon MSMS to request hospitals to provide liability coverage for physicians providing services to unattended patients in hospital out-patient clinics and emergency departments that are not part of the physician's practice.

The resolution was referred to the MSMS/HMSS Governing Council. It was noted that many physicians are uneasy about providing care to uninsured

patients who might then bring a malpractice suite against them.

The resolution was then forwarded to the Michigan Health and Hospital Association where it was reviewed by its Council of Physicians. The Council suggested that some hospitals are already providing liability coverage for such occurrences, and that MHA could suggest this approach to its members. It was further noted that such coverage is available through the MHA Insurance Company.

66-95A Title: Physician Liability Coverage for Mandatory Hospital Clinic Coverage. Substitute Resolution (in lieu of 65-95A and 66-95A). Adopted. See Resolution 65-95A.

67-95A Title: State of Michigan Medical Liability Coverage for Volunteer Physicians. Referred to the Board for Study.

This resolution requested that MSMS seek legislation making the state responsible for providing liability coverage to volunteer physicians and was referred to the MSMS Board of Directors for further study.

The MSMS Board of Directors referred this resolution to the MSMS Committee on State Legislation and Regulations. The Committee on State Legislation and Regulations reviewed this resolution at their January 31, 1996,

meeting.

Committee members believe that many physicians who would normally provide volunteer care choose not to due to liability concerns. In addition, it was noted that many parts of the state suffer from relatively poor access to volunteer medical care, and expanding the Good Samaritan Act to include volunteer physician care may be one way to address the access problem. Expanding the Good Samaritan Act would give retired physicians the opportunity to utilize their skills as physicians and help alleviate a societal problem.

After a great deal of discussion, the Committee recommended to the Board of Directors that MSMS support legislation that would expand the Good Samaritan Act to include physicians providing volunteer care. MSMS has discussed this matter with lawmakers who have agreed to sponsor legislation at

the appropriate time.

68-95A Title: State of Michigan Liability Coverage for Volunteer Physicians in Free Clinics. Referred to the Board for Study.

This resolution requested that MSMS seek legislation that requires state provided liability coverage for physicians who provide services at recognized free clinics.

The Committee on State Legislation and Regulations discussed this resolution as well as the need for the resolution. Committee members believe that many physicians who would normally provide volunteer care choose not to due to liability concerns. In addition, it was noted that many parts of the state suffer from relatively poor access to volunteer medical care, and expanding the Good Samaritan Act to include volunteer physician care may be one way to address the access problem. Expanding the Good Samaritan Act would give retired physicians the opportunity to utilize their skills as physicians and help alleviate a societal problem.

The Committee on State Legislation and Regulations recommends that MSMS support legislation that would expand the Good Samaritan Act to apply to all volunteer physician treatment. MSMS has discussed this matter with lawmakers who have agreed to sponsor legislation at the appropriate time.

69-95A Title: Amendment to Employee Retirement Income Security Act (ERISA) Regarding State Mandates for Health Insurance Coverage of Immunizations. Approved.

This resolution asked the Michigan Delegation to the AMA to ask the AMA to seek legislative change to the ERISA of 1974 to require self-insured entities to comply with present and/or future state regulations that mandate coverage for vaccines and vaccine administration in health insurance policies.

The Michigan Delegation forwarded this resolution to the June 1995 AMA Annual Meeting, where a substitute was adopted. The substitute calls on the AMA to collect and widely disseminate information on the cost-effectiveness of immunization programs; to advocate strongly that all health plans, including

self-insured plans governed by ERISA, provide coverage and payment for immunizations recommended by the CDC, and for the AMA Board to study and report back the advantages and disadvantages of state mandated taxes, surcharges or other financial assessments on self-insured ERISA health plans.

The AMA Board reported to the 1995 AMA Interim House of Delegates in December, where their report was amended. It calls for the AMA to continue to educate physicians and patients on private sector educational strategies related to immunization coverage; to continue to monitor and advise physicians on opportunities to advance new state laws to bring about broad-based health system reform initiatives, and to investigate ways to use the state tax laws to impose accountability on ERISA regulated managed care plans; where appropriate, to draft model legislation to assist the federation on these issues.

70-95A Title: Unfunded Mandates by Joint Commission on Accreditation of Healthcare Organizations (JCAHO). No Action.

71-95A Title: Alcohol During Pregnancy. Adopted as Amended.

This resolution requested that MSMS seek legislation requiring signs in bars and restaurants and on menus, advising the damage that may occur to the baby when alcohol is used during pregnancy, thereby reducing the use of alcohol during pregnancy and related damage to unborn children.

MSMS sought the introduction of SB 469, which provides mandatory warnings regarding the use of alcohol during pregnancy on liquor advertising inside licensed premises. The legislation is currently pending in the Senate Committee on Health Policy and Senior Citizens. MSMS will continue to seek passage of this legislation.

72-95A Title: Physician Extenders. Adopted as Amended.

The resolution requested MSMS to study the role of physician extenders, with the objective of developing guidelines for use by employers.

MSMS has reviewed guidelines that several payers use for payment to physician extenders. In previous years, MSMS has been active in developing guidelines for collaborative agreements between physicians and nurse practitioners that are used by the Medicaid program; for a pilot program involving certified nurse midwives; and for contractual provisions relating to the issue of direct supervision by physicians. Our involvement in these processes provide useful background for developing MSMS guidelines. Currently, pilot programs involving nurse practitioners are under review and our review will be used in the development of future guidelines.

73-95A Title: Helmets for Cyclists. No Action.

74-95A Title: Medical Insurance Plans. Adopted as Amended.

This resolution requested that MSMS seek legislation to require employers providing medical insurance to offer at least one point-of-service or open panel medical insurance option and educate employers and employees about the availability and flexibility of medical savings accounts.

MSMS has expressed support for legislation requiring employers to offer at least one point-of-service or open panel medical insurance options. MSMS has expressed support of this legislation to be included in the Michigan Patient Bill of Rights. The Michigan Patient Bill of Rights, House Bills 5570-5574, has been introduced, but at this time, does not include a point-of-service provision. That provision may be included at an appropriate time. MSMS also supported legislation that would provide state tax exempt status of medical savings accounts. This legislation passed in 1994 with the assistance of the Michigan State Medical Society. MSMS will continue to work with other organizations to educate employers and employees about the availability and flexibility of medical savings accounts.

75-95A Title: Medicaid Population. Referred to the Board for Study.

This resolution requested MSMS to develop and present its own plan for providing care to the Medicaid population by physicians in the State of Michigan.

MSMS and MAOPS have been involved in the evolution of Michigan's Medicaid system by assisting in the creation of the Physician Sponsor Plan (PSP) in the late 1970's.

Currently MSMS is working with Vernon Smith, PhD, and staff of the Medicaid Services Administration Division discussing possible quality based capitation approaches that would be applicable to the current Physician Sponsor Plan (PSP).

PO and PHO representatives met with Vern Smith, PhD, and Bob Smedes on February 1, and expressed strong interest in contracting directly with Medicaid. In this event, these entities should not be subject to the same solvency requirements as HMO's in order to ensure that they can meet their financial

Another option MSMS presented to Doctor Smith and Mr. Smedes would be to allow PO's, PHO's and other similar entities to directly contract with Medicaid to accept capitation for professional services only. Because these entities would be at risk for professional services only, they should not be required to comply with the same solvency standards that are imposed on HMO's.

MSMS will convene additional meetings between Medicaid officials and representatives of Michigan POs, PHOs and interested physicians to continue dialogue on this issue.

76-95A Title: Michigan Physicians Mutual Liability Company (MPMLC). Substitute Resolution. Adopted.

This resolution asked that the agreement (if MPMLC did choose to demutualize, the draft plan be submitted to the MSMS Board of Directors (in a timely fashion) for approval prior to submission to the insurance commissioner or policy holders) of March 15, 1995 as reflected in the Chair's announcements of the Board minutes of that day, be considered protective of the equity interests of Michigan doctors in MPMLC.

MSMS will watch closely if and when MPMLC chooses to demutualize.

77-95A Title: Health Education in Detroit Public Schools. Adopted as Amended.

This resolution asked MSMS to support health education classes in all public schools starting at the elementary school level and to encourage physician involvement at the local level in the development and implementation of health education curricula.

The Liaison Committee with Michigan Department of Public Health met in May 1995, and heard a presentation from Scott Chapman and Charles Kuntzleman PhD, regarding the Michigan Fitness Foundation. The Governor's Council on Physical Fitness, Health, and Sports was created by Governor John Engler in 1992. One of the primary objectives of the Michigan Fitness Foundation, is to strongly encourage public schools to provide an effective health education and fitness curriculum. The Michigan Fitness Foundation is working with public schools to implement such curriculum.

The Liaison Committee with Michigan Department of Public Health recommended that MSMS physicians be appointed to statewide curriculum development committees of the Foundation at local and regional levels, and assist the Michigan fitness efforts of the Michigan Fitness Foundation using MSMS communication tools.

- 78-95A Title: Health Care Professional Drivers License Suspension. Substitute Resolution (in lieu of 5-95A, 26-95A and 78-95A). Adopted. See Resolution 5-95A.
- 79-95A Title: MSMS Representation on the Board of Medicine.
 Disapproved.

80-95A Title: Increase in Sexually Transmitted Diseases. Substitute Resolution. Adopted.

This resolution requested MSMS to support legislation to require the availability of comprehensive health education whose content is community determined for all K-12 students in Michigan.

MSMS worked with the Michigan Department of Education to ensure that comprehensive health education programs shall be developed. Health and physical education for pupils of both sexes shall be established and provided in all public schools of this State. A school district may credit a pupil's participation in extracurricular activities involving physical activity as meeting the physical education requirement.

81-95A Title: Availability of Latex-Condoms in Schools. Adopted as Amended.

This resolution requested MSMS to seek legislation rescinding current legislation which prohibits schools from dispensing devices to prevent sexually transmitted diseases.

MSMS will continue to work with the legislature to communicate concerns regarding current law which states: A district in which a school official, member of a board, or other person dispenses or otherwise distributes a family planning drug or device in a public school in violation of Section 1507 of the School Code of 1976, being Section 380.1507 of the Michigan Compiled Laws, dispenses prescription for any family planning drug, or make referrals for abortions shall forfeit 5% of its total state aid appropriation.

82-95A Title: Access to the Michigan Health Council's Employment Opportunity Listings on the MSMS Internet Home Page. Approved.

This resolution asked MSMS to provide access to the Medical Opportunities in Michigan Internet homepage, and also to provide phone numbers and general information regarding MHC and MOM. It was further resolved that MSMS

advertise the availability of MOM through MSMSNET.

MSMSNET developed a substantial home page for MOM, which included all the requested information plus a great deal more. A general information page was incorporated as a part of the MSMSNET initially. MOM as a distinct presence, and a unique homepage became available in January 1996. The MOM homepage includes information about MOM services as well as an extensive on-line interactive form. Since the initial unveiling of MOM on the Internet, a number of informational articles have been printed in Medigram to promote its use.

83-95A Title: Copay for Patients Enrolled in Medicaid's Physician Sponsor Plan (PSP). Adopted as Amended.

This resolution requested MSMS actively pursue revisions in the current Physician Sponsor Plan (PSP) to provide for shared risk and liability relief between the Plan and physicians for the care of patients and work with appropriate state departments to seek new strategies to effectively redress the abuses taking place in the PSP Program.

After review and consideration by the MSMS Medicaid Liaison Committee in discussion with Vernon Smith PhD, Director, Division of Medicaid, if a copay was implemented it would be the physician who would be responsible to collect the copay from the patient. In reviewing the history of Medicaid reimbursement, physicians have not received a raise since September, 1991. Medicaid was not willing to collect the copay due to the amount of additional work.

In September, 1995, Vern Smith PhD, informed the MSMS Medicaid Liaison Committee that the Administration has clearly stated that they are moving towards capitation of the Physician Sponsor Plan as the core of the recodified Medicaid system in order to gain more control over costs. Doctor Smith has also stated his desire to continue to work with MSMS and MAOPS throughout this extensive process. At this time this project has been put on hold due to the reorganization of State government.

Title: Funding for Resident Physicians Section Representation at National Meetings. Adopted as Amended.

This resolution asked MSMS to provide up to \$10,000 annually for funding for Resident Physicians Section (RPS) representation at the American Medical Association Resident Physicians Section (AMA-RPS) Annual and Interim meetings and the Annual AMA Leadership Conference.

The fiscal year 1996 Operating Fund Budget provides the Resident Physicians Section (RPS) with \$10,000 in financial support for the residents to

AMA meetings.

85-95A Title: Dissolution of the Certificate of Need. Approved

This resolution asked MSMS to seek legislation rescinding the Certificate of Need requirement for cost-effective ambulatory surgical center development.

The Certificate of Need Commission passed the new revised standards for surgical outpatient services at their Tuesday, December 12, 1995 meeting. MSMS voiced its opposition to the new proposed CON surgical outpatient services standards as this position was taken at the 1994 House of Delegates. In a letter to the CON Commission, MSMS stated that the Certificate of Need Process is slow, lengthy and impedes and discourages new development to medical facilities necessary to fulfill potential costs savings through capitation and other managed care models.

MSMS physician members have testified on several different occasions regarding their concerns for these increased restrictions to providing surgical

care on an outpatient basis for far less costs.

MSMS will continue to work with the legislature to introduce and pass legislation that would repeal CON requirements in Michigan.

86-95A Title: Compassionate Care and Comfort Guidelines. Adopted.

This resolution called for MSMS to adopted the compassionate care and comfort guidelines as being in compliance with the standard of care.

The guidelines for compassionate care and comfort as written in resolution 86-95A have been included in the Official Positions and Policies of MSMS.

87-95A Title: Psychologists Prescribing Medications. Adopted as Amended.

This resolution requested that MSMS oppose the legislative effort by psychologists the privileges to prescribe medication.

While legislation has not yet been introduced that would give psychologists the privileges to prescribe medications, MSMS is closely tracking this initiative and will continue to strongly oppose such legislation.

88-95A Title: Emotional Disorder as a Pre-Existing Condition. Adopted as Amended.

This resolution requested that MSMS seek legislation to ensure that no applicant be denied an insurance policy for health care, sickness and accident, and/or life, because the applicant has been treated for any current or previous emotional disorder.

House Bills 5570-5574 (the Michigan Patient Bill of Rights), were recently introduced. Among other things, this legislation would prohibit health plans from denying coverage based on any pre-existing condition, including emotional disorders after a six month period. MSMS, along with various volunteer health agencies, have sought the introduction of this important legislation and will continue to seek passage of this legislation as a part of MSMS top priority for 1996. MSMS has built a strong coalition (the Michigan Partners for Patient Advocacy) which continues to expand in membership. This coalition will engage in a statewide campaign to seek passage of this legislation. Hearings have begun in the House Health Policy Committee.

Title: Managed Care Information System. Disapproved.

Title: Scheduled Fees of Blue Cross Blue Shield (BCBS) in Other States. Adopted.

This resolution asked for MSMS to pursue remedies to the recent BCBSM contract change, whereby payment for services to patients from other states is made based on the Michigan fee schedule.

Information on the impact of this contract change was presented to the Michigan Insurance Bureau in MSMS testimony on the BCBSM Provider Class Plan, which includes the Blues' participating agreements. MSMS urged the Commissioner to prohibit the Blues from further enforcing this provision. Currently, MSMS is awaiting the Commissioner's determination on the BCBSM Provider Class Plan.

Title: Suicides and Malpractice. Approved.

This resolution requested MSMS to seek legislation that has the same requirements for reporting or hospitalization suicidal patients as the Michigan law for patients who have the intent of inflicting physical violence and who have the ability to carry out that threat in the foreseeable future.

MSMS will continue to work with legal counsel in reviewing the current legislation which states: "A psychiatrist, psychologist or psychiatric social worker has a duty to warn a third party if the patient makes threats of violence against that third party under specified circumstances." In our initial review of the case history in this area we found that 5 to 6 percent of suicides in America occur in a hospital. MSMS will continue to research and seek legislation regarding this issue.

Title: Access to Psychiatrists. Substitute Resolution (in lieu of 92-95A and 101-95A). Adopted.

This resolution requested that MSMS seek legislation requiring qualified

health plans to provide access to psychiatrists.

As a part of the Michigan Patient Bill of Rights, MSMS is seeking legislation that would establish utilization review standards which would state when an adverse determination is involved, a physician of the same medical specialty as the treating physician, review the medical necessity of the recommendation for services or referral. This type of legislation is expected to address access to psychiatric care. MSMS is also seeking legislation that would establish an appeals and grievance mechanism to allow patients and providers to appeal adverse determinations and other health plan policies. Legislation has also been introduced that would require insurance companies and managed care organizations, to cover mental health services. MSMS will continue to advocate for legislation requiring health plans to provide access to psychiatrists.

93-95A Title: Long Term Psychotherapy. Adopted.

The resolution asked MSMS to oppose arbitrary establishment of limits on psychotherapy visits.

MSMS has developed Principles for Utilization Management and Medical Review which oppose arbitrary limits on all services. These principles have been broadly disseminated and discussed with managed care companies and

Continued on page 58



Miriam Daly, MD, Albion, is this year's recipeint of the MSMS Plessner Award for the rural physician most closely exemplifying the traditional, dedicated family doctor. Doctor Duhamel made the presentation.



Krishna K. Sawhney, MD, Taylor surgeon (center), is next chair of the MSMS Board of Directors. He succeeds Doctor Duhamel (right).







Section chairs reporting to the 1996 MSMS House of Delegates included (from left) Tama D. Abel, MD, Young Physicians; Edward J. Rutkowski, MD, Organized Medical Staffs; and Lee Benjamin, Medical Students.



1995-96 MSMS Alliance President Jean Howard, Traverse City, described the year's Alliance activities to the House of Delegates

Speaker's Report (continued)

other payers. MSMS also has been active in the review of BCBSM's "focused procedures," procedures which the Blues have identified as having higher than average use trends. Psychotherapy has been on the list of focused procedures, and we have urged BCBSM to discuss these issues with the Michigan Psychiatric Society, to assure that utilization management initiatives are developed in concert with practicing Michigan psychiatrists, not on arbitrary limits.

94-95A Title: Gatekeepers. Adopted as Amended.

This resolution asked MSMS to urge the appropriate state agencies and organizations to ensure that sufficient and appropriate services of psychiatrists be a part of the determination of medical necessity, treatment planning, and psychiatric hospitalization of Medicaid patients in the staffing of community mental health personnel.

MSMS joined with the Michigan Psychiatric Society (MPS) in the recodification of Michigan Mental Health Code (SB 525). MSMS/MPS were successful in establishing a Medical Director position with in the Community Mental Health System. The language describing the duties of the Community Mental Health Services Programs (CMHSP) medical director, was successfully carried by Senator John Schwarz, MD (R-Battle Creek). This is a significant commitment for CMHSP to move forward with increased medical leadership and involvement.

95-95A Title: Director of the Michigan Department of Mental Health. Adopted as Amended.

This resolution requested MSMS to seek legislation requiring that either the Director or the Deputy Director of the Michigan Department of Mental Health be a physician licensed in the state of Michigan.

MSMS and the Michigan Psychiatric Society (MPS) lobbied legislators to have the Michigan Department of Mental Health appoint a medical director who is a physician, who has completed a psychiatric residency program accredited by the accreditation council for graduate medical education or the American Osteopathic Association, and has at least five years or clinical and two years of administrative experience. The efforts of MSMS and MPS were not successful in their lobbying efforts to have a physician appointed as medical director of the Michigan Department of Mental Health.

96-95A Title: Protecting Progress Notes. Approved.

This resolution requested that MSMS seek legislation stating that physicians do not have to submit progress notes to insurance companies, but they may release relevant information such as the diagnosis, the reasons to support the diagnosis, the degree of

impairment and the estimated time the person will remain impaired.

House bills 5570-5574 (the Michigan Patient Bill of Rights), was recently introduced and referred to the House Health Policy. This legislation makes significant changes to the health insurance and managed care system. While this legislation is the first phase among many, it is expected that further legislation would state that physicians do not have to submit progress notes to insurance companies, but only pertinent information relating to diagnosis and the patient's status. This further legislation will be reviewed on an ongoing basis and will be introduced at an appropriate time.

- 97-95A **Title: Profits.** Substitute Resolution (in lieu of 28-95A and 97-95A). Adopted. See Resolution 28-95A.
- 98-95A Title: Case Management. Disapproved.
- 99-95A **Title: Confidentiality.** Substitute Resolution (in lieu of 18-95A and 99-95A). Adopted. See Resolution 18-95A.

100-95A Title: Patient Protection Act. Referred to the Board for Study.

This resolution requested that MSMS support the Michigan Patient Protection Act in that it requires a point-of-service option, allowing patients to seek care outside the network and that it provides various protection for physicians against de-selection by plans and that MSMS propose to modify the Michigan Patient

Protection Act as suggested by the Patient Access to Specialty Care Coalition representing many non-primary care specialty groups and that these plans must offer point-of-service in every policy rather than as an option.

The MSMS Board of Directors referred the resolution to the Michigan Patient Protection Act Task Force. The MPPA Task Force discussed this resolution in depth and recommended various portions of the recommendations be included in the Michigan Patient Bill of Rights. Due to the fact that the

Michigan Patient Bill of Rights is an on-going developmental process, the MPPA Task Force agreed that the resolution be reviewed on a regular basis by the Task Force and continue to recommend changes to the bills as needed.

101-95A **Title: Excluding Psychiatrists.** Substitute Resolution (in lieu of 92-95A and 101-95A). Adopted. See Resolution 92-95A.

102-95A **Title: Streamlining of Organized Medicine.** Referred to the Board for Study.

This resolution asked MSMS to establish a task force to look at ways to reduce the costs of running county medical societies, and that MSMS look at ways that could help reduce the duplicative costs incurred in operating state and multiple county medical societies.

This resolution called for a standing committee or task force to do what already is being done continuously by the MSMS Strategic Planning Committee, MSMS officers, various MSMS committees and senior staff. It is the opinion of the Strategic Planning Committee and the MSMS Board of Directors that it would be redundant to act on this resolution.

The Strategic Planning Committee, made up of MSMS officers and senior staff, formally meets each one to two years to update the three-year strategic plan with American Medical Association strategic planner Bruce Balfe. Mr. Balfe takes the Committee through a detailed discussion of the current "environment," the achievements since the last plan was developed and implemented and a detailed discussion and analysis of what the Committee believes to be the most important activities and directions for MSMS for the next several years. A written document is prepared by Mr. Balfe and distributed to leadership and senior staff and is available upon request by individual members. Highlights are usually presented in Medigram and Michigan Medicine.

103-95A Title: Smoke Free Hospital Doorways. Approved.

This resolution called for MSMS to support a no smoking zone of 100 feet from each entrance to a hospital.

This resolution was referred to the MSMS/HMSS Governing Council which in turn forwarded the resolution to the Michigan Health and Hospital Association where it was reviewed by its Council of Physicians.

There was strong support for this resolution and the council also suggested that the language be extended to include all physician offices as well. There did appear to be a need for some clarification regarding the current working of Michigan law.

104-95A Title: Blue Cross Blue Shield (BCBS) Payments. Adopted as Amended.

The resolution called for MSMS to seek appropriate allocation of BCBSM dollars to physician payments.

Through MSMS representation on the BCBSM Physician Contract Advisory Committee, MSMS has made some progress in achieving more equitable payment for physician services. The 1996 payment changes, were developed using an economic indicator - the Medicare Economic Index - adjusted to reflect use trends in physician services, hospital services and prescription drugs. This represents the first time BCBSM has considered physicians' role in achieving more favorable use trends for hospital services. MSMS will continue to refine this effort as changes for 1997 are developed. A priority will be to assure that the Blues' continued transition to the Resource Based Relative Value Scale does not mitigate the positive impact of payment changes approved by the BCBSM Board of Directors.

105-95A Title: Violence. Approved.

This resolution requested that MSMS work with the state legislature and Governor to encourage the news media to actively participate in sending out a strong message against violence; educate children at elementary level regarding the pitfalls of violence; encourage schools to include discussion in parent/teacher conferences to help young children to resolve conflict and solve problems without resorting to violence.

As in past years, MSMS continues to seek passage of strong anti-domestic violence and other violence measures. As a part of this overall initiative, MSMS is working with the State Task Force on Violence to pursue the goals of this important resolution. The Michigan Department of Public Health, through its Task Force on Violence, has expressed a strong commitment to the overall objectives of this resolution. MSMS will continue its anti-violence efforts through its representation at the state level and through its resources of the Communications Department.

106-95A Title: Autopsy Criteria. No Action.

Announcing the 1996 Michigan **Regional Immunization** Conferences

This one day conference will provide participants with an assortment of practice-management tools, techniques, and information that will help assure that all of their two-year-old patients are fully immunized.

The conference is appropriate for physicians, physician assistants, nurses, public health staff, medical and nursing students, and anyone interested in learning more about current immunization practice in Michigan.

Program Content:

- Tips for administering vaccines to those very active and anxious infants, children, and teens-how many pairs of arms do you need?
- Update on new vaccines, new immunization schedules, and new recommendations-is eIPV in your future?
- Adolescent immunization visit-how do you reach them and make this visit part of your routine?
- Review of immunization coverage assessments in private practices-how does your practice measure up?
- Immunization registries in Michigan-are you ready to jump on board?
- Appropriate immunization documentation-will it help you avoid liability concerns?
- Ongoing immunization education activities-how can you stay up to date?

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Conference Dates and Locations:

October 16 - Gaylord October 18 - Marquette November 6 - Grand Rapids November 14 - Novi

Conference times: 8:30-3:00; Registration fee: \$25

Speakers:

Speakers will include representatives from local health departments, Michigan Department of Community Health, and community providers.

Co-sponsored by:

Association of HMOs in Michigan; Michigan Association for Local Public Health;

Michigan Association of Osteopathic Physicians and Surgeons, Inc.; Michigan Chapter, American Academy of Pediatrics; Michigan Council for Maternal and Child Health; Michigan Department of Community Health;

Michigan 4C Association; Michigan Health & Hospital Association;

Michigan Nurses Association; Michigan Primary Care Association; Michigan State Medical Society; National Association of Pediatric Nurse Associates and Practitioners; Society of Pediatric Nursing, Great Lakes Chapter and West Michigan Chapter

Speaker's Report (continued)

107-95A Title: Communications Between State Prisons and Health Departments. Approved.

This resolution asked MSMS to work with the Michigan Department of Public Health (MDPH) to improve communications of health care data between

state prisons and county health departments.

MSMS is working with the Michigan Department of Public Health to provide assistance in its planning for and development of a statewide immunization tracking system. This will provide a registry for all immunizations given to children in the state. The registry would collect data from local health departments, private physicians and other provider of childhood immunizations, and would provide health care providers, schools and other authorized users with up-to-date immunization histories for these children. MSMS will continue to work on this effort and also incorporate the state's prison system.

108-95A Title: Contracts for Purchasing Practices. Approved.

This resolution asked that MSMS appoint a task force to look into the purchase of physician practices and to develop a strategy for dealing with this issue. The resolution also asked MSMS to advise physicians concerning the key issues to be aware of in these agreements.

MSMS has appointed a task force, chaired by Krishna K. Sawhney, MD, that is examining the issues raised by this resolution. The Task Force has examined the many legal and business issues involved in the purchase of physician practices. The Task Force will finalize the list of key issues and publicize the list in *Michigan Medicine* and/or sponsor a seminar.

109-95A Title: Encourage Establishment of Compassionate Futile Care Guidelines to be Endorsed by the Medical Profession. Referred to the Board for Study.

This resolution asked that MSMS develop a futile care policy to include the physician's first responsibility to maintain the dignity of their patients at times of impending death by; a) keeping them comfortable, b) not subjecting them to unnecessary tests, c) not subjecting them to treatments which are unproven and/or painful when there is no realistic chance of benefit and which may prolong unnecessary suffering, and d) holding compassionate discussions, among the patient, the physician, the patient's family, and other loved ones.

The Committee on Bioethics discussed this resolution at length and concluded that the drafting of "compassionate futile care guidelines" by MSMS would not be useful at this time, for reasons elaborated below; but that the Board may wish to consider other means to address these important concerns.

The resolution assumes that physicians and patients and/or their families will agree among themselves on when medical treatment is "futile." In such circumstances, the resolution lists four directives to physicians, which the Committee finds uncontroversial and hardly in need of restatement. But there is a voluminous and heated debate now occurring within the medical literature on futility; and the debate has to do precisely with circumstances in which that assumption does not hold--when physicians disagree with patients or families about what treatments are futile.

That debate reveals the serious controversy about several important points: how is "futility" to be properly defined? Is futility a purely scientific and technical decision or a value-laden and, hence, ethical decision? Should physicians be entitled unilaterally to refuse to offer futile treatment, even over objections of patients or families? How should disputes over futility determinations be resolved in health care settings? Is futility a matter of professional principle, cost containment, or perhaps both?

The Committee on Bioethics finds that the present state of controversy would make any "futile care guideline" issued by MSMS of dubious value, assuming that the guideline did attempt to grapple with the serious ethical concerns. The best MSMS could do would be to summarize the relevant literature and suggest that interested physicians read that literature in order to make up their own minds.

110-95A Title: Rescinding Single Copy Prescription Forms. No Action.

111-95A Title: Continuous Quality Improvement (CQI) Programs. Adopted.

This resolution asked MSMS to urge members to participate in Continuous Quality Improvement (CQI) training programs, to provide information re CQI programs, incorporate CQI into ongoing CME programs and sponsor training programs for members.

MSMS has responded to the demand for CQI education in several ways. A course was presented at the 1995 Annual Scientific Meeting in Lansing; the November Masters Series conference focused on outcomes measurement; several

CQI topics were included as part of the 1995 Physician Executive Leadership Institute series, in cooperation with University of Michigan; the March, 1996 issue of Michigan Medicine contains an article on CQI; some topics are being addressed as part of the 1996 Masters Series on managed care and another session is being developed for the 1996 Annual Scientific Meeting. MSMS recognizes the importance of continuous quality improvement education for physicians and will continue to support and develop such programs.

112-95A Title: Protect the Public's Health from Vaccines Preventable Diseases Through a Statewide Barrier-Free Immunization Effort.
Not Accepted as a Late Resolution.

94-90A **Title: Forward Planning For Medicine.** Referred back to the Board for Further Study.

This resolution asked that MSMS constitute a standing committee (Think Tank) charged with the contingency planning of viable responses to possible future changes with a time horizon of not less than three years, and for MSMS to ask the AMA to constitute a standing committee (Think Tank) charged with the contingency planning of viable responses to possible future changes with a time horizon of not less than three years.

This resolution called for a standing committee or task force to do what already is being done continuously by the MSMS Strategic Planning Committee, MSMS officers, various MSMS committees and senior staff. It is the opinion of the Strategic Planning Committee that it would be redundant to act on these

resolutions individually.

The Strategic Planning Committee, made up of MSMS officers and senior staff, formally meets each one to two years to update the three-year strategic plan with American Medical Association strategic planner Bruce Balfe. Mr. Balfe takes the Committee through a detailed discussion of the current "environment," the achievements since the last plan was developed and implemented and a detailed discussion and analysis of what the Committee believes to be the most important activities and directions for MSMS for the next several years. A written document is prepared by Mr. Balfe and distributed to leadership and senior staff and is available upon request by individual members. Highlights are usually presented in Medigram and Michigan Medicine.

The future planning process at MSMS, however, is not a once-every-year-or-two event. MSMS officers and senior staff work together daily to assess the health care environment, read the membership and make course changes to fulfill the "vision" of the organization. This is an effective process at MSMS that has been bred into leaders and senior staff for decades and has proven again and again to be effective.

Additionally, for the past two-and-one-half years, the American Medical Association has undertaken a \$2.5 million study of the entire federation of organized medicine, from county medical societies all of the way through the AMA, to determine how best to improve the efficiency and effectiveness of the federation. More than 250 representatives of the AMA, state medical societies, specialty societies and county medical societies have participated, including 20 from Michigan including MSMS Board member Cathy O. Blight, MD, and MSMS Executive Director William E. Madigan. The completed federation study will be used by MSMS as another tool in planning its own future. To replicate this type of study on the state and county level would be cost prohibitive and redundant.

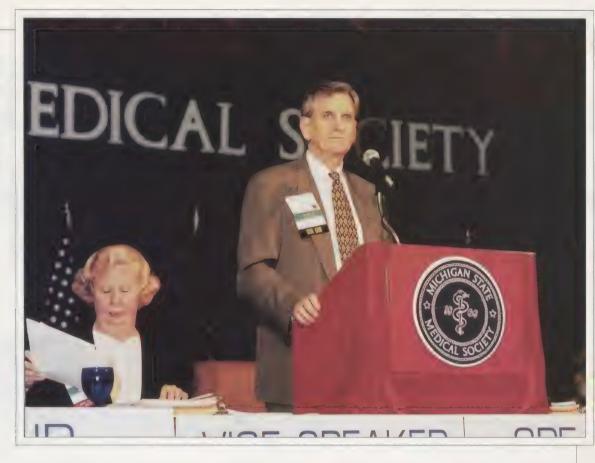
Errata

Michigan Medicine regrets the following errors which inadvertently appeared in recent issues. To set matters straight, the following should be noted:

There are actually 79 Michigan institutions accredited to offer CME programs, rather than 29, as incorrectly reported on page 26 of the June 1996 Michigan Medicine.

The good news is that James P. Gallagher, MD, Allen Park cardiovascular disease specialist, was installed May 11 as Wayne County Medical Society president; and that Michael A. Sandler, MD, West Bloomfield diagnostic radiologist, was named new WCMS president-elect. The bad news is that this good news inadvertently appeared in the obituaries column of the June 1996 Michigan Medicine. We wish successful tenures and long life to both Wayne County leaders!

During the meeting, the gavel of House leadership passed from Gary D. Maynard, MD (standing), to Dorothy M. Kakhonen, MD (seated), formerly vice speaker. Doctor Maynard has relocated to Texas, but returned to fulfill his duties as Speaker.



AMA Board Member Donald T. "Ted" Lewers, MD, Maryland (right) updated MSMS Delegates on restructuring of the House of Medicine.





Guest speaker Stuart Fleischman, California, described the workings of his successful medical service organization (MSO) to MSMS Delegates, who approved startup plans and financing for an MSMS MSO.

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Physician Senior Management Leader

Covenant Health System (CHS) is seeking candidates to provide leadership in systems which improve individual and collective outcomes for those served by CHS. The Physician Leader will be part of a five-person management team which includes the President. This team constitutes the senior leadership for Covenant Health System.

The Physician Leader is responsible for the development of the Population Health Management system as part of the design for managing current and future health care services, known as Community Based Individually Coordinated Care (CBICC). The leader's role is to inspire shared understanding and commitment to Covenant Health System's mission, vision and values; to understand the Population Health Management System's role and integrate it into the larger CBICC system. For the medical staffs, the leader will direct the personnel assigned to support elected medical staff leadership in carrying out functions under the Bylaws, Rules and Regulations. The leader is expected to commit to the management tenets, lead fundamental change efforts, identify and model the role and participate in community activities as a representative of Covenant Health System.

The ideal candidate will be an experienced community practice physician possessing excellent clinical credentials and board certification. The candidate should be able to demonstrate current knowledge of medical care in today's changing health care delivery system as well as management and leadership talents as evidenced by past medical staff participation, management training and or/related experiences. A comfortable working knowledge of Continuous Quality Improvement techniques and beliefs as well as excellent communication skills are necessary.

If you are interested in more information or wish to submit a C.V. for consideration, please contact:

Julie A Marcuzzo, PHR, Employment Coordinator
Covenant Medical Center • 3421 W. 9th Street • Waterloo, IA 50702 • PH: (319) 292-2330

Janice Yagla, *Physician Placement Coordinator*Covenant Medical Center • 3421 W. 9th Street • Waterloo, IA. 50702 • PH: (319) 236-4200

FAX: (319) 236-4048 EOE/Drug Screen Required

Election Results

Delegates elect colleagues to MSMS posts.

he 1996 House of Delegates elected the following MSMS officers and directors, as well as delegates and alternates to the American Medical Association.

Officers (to the 1997 House of Delegates)

President W. Peter McCabe, MD, St. Clair Shores
President-elect .. Peter A. Duhamel, MD, Rochester Hills
Secretary Thomas R. Berglund, MD, Portage
Assistant Secretary Thomas C. Payne, MD, East Lansing
Treasurer Billy Ben Baumann, MD, Pontiac
Assistant Treasurer .. Earl G. Moehn, MD, Mt. Clemens
Speaker Dorothy M. Kahkonen, MD, Detroit
Vice-Speaker Paul O. Farr, MD, Grand Rapids



District Directors (to the 1997 House of Delegates)

1st District Hassan Amir	ikia, MD, Detroit
	eiss, MD, Livonia
Krishna K. Saw	hney, MD, Taylor
Cecil R. Jonas	, MD, Southfield
7th District David Moore Hislop,	MD, Port Huron
8th District T. Anthony Eglesto	on, MD, Saginaw
10th District Devendra K. Sharma,	MD, Tawas City
12th District Jaak M. Pahn, MD,	Sault Ste. Marie
14th District Rudi Ansbacher	, MD, Ann Arbor
15th District Mark D.	Kolins, MD, Troy

Delegates to the AMA (to the 1998 House of Delegates)

Busharat Ahmad, MD, Monroe Billy Ben Baumann, MD, Pontiac Cathy O. Blight, MD, Flint Gilbert B. Bluhm, MD, Troy Michael App (Student), Royal Oak Krishna K. Sawhney, MD, Taylor Willard S. Stawski, MD, Grand Rapids

Alternate Delegates to the AMA (to the 1998 House of Delegates - in order of seniority)

John W. Hall, MD, Petoskey Domenic R. Federico, MD, Grand Rapids Thomas E. Stone, MD, Muskegon Dorothy M. Kahkonen, MD, Detroit Philip J. Boyer, MD, PhD, (Resident) Ann Arbor Hassan Amirikia, MD, Detroit Cecil R. Jonas, MD, Southfield

Peter A. Duhamel, MD, Rochester Hills general surgeon, was chosen president-elect of MSMS. He will take office as the 132nd MSMS president in May 1997.

DELEGATES' RECORD OF ATTENDANCE APRIL 26 - 28, 1996 MEETING

	1 st	2nd	3rd	BAY			
OFFICERS:				Scott A. Baker, MD Mark C. Komorowski, MD Bernhardt L. Pederson, MD Carol VanderHaarst, MD	X	X	X X
Speaker: Gary D. Maynard, MD	Х	Х	Χ.	BERRIEN Fred M. Busse, MD	Х		X
Vice Speaker: Dorothy M. Kahkonen, MD	Х	Х	Х	Thomas D. Huntington, MD Linda K. Stanley, MD Dennis C. Szymanski, MD	X X X	X X	X
Secretary: Thomas R. Berglund, MD	Х	Х	Х	BRANCH Jeffrey C. Custer, MD	_	X	_
DELEGATES AND ALTE	RNATES			Regio T. Penna, MD	_	_	Χ
ALLEGAN Not Represented	_	_	_	CALHOUN Russell K. Ameter, MD Marjorie J. Hickman, MD Robert W. Oakes, MD	X		
ALPENA—ALCONA—PRESQU Richard D. Bates, MD	_	_	_	Mohammad R. Siddiqui, MD Dale Syverson, MD	X	X	
Peter Aliferis, MD	Χ	Х	Χ	CASS Boonchoo Chang, MD	Х	Х	Х
BARRY David M. Woodliff, MD	Х	Х	Х	CHIPPEWA—MACKINAW Edward N. Johnson, MD	X		Х

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CLINTON Not Represented				JACKSON Cathy L. Glick, MD	X	X	Χ
				Moses Muzquiz, MD	X	X	
DELTA				Bernard Z. Reizner, MD	X	Х	_
Carol A. Krieg, MD	Χ	X	X				
				KALAMAZOO			
DICKINSON—IRON				Donald H. Batts, MD	_	Χ	X
Gope C. Hotchandani, MD			_	Owen M. Berow, MD	X	X	X
_				Thomas M. George, MD		X	
					X	x	X
ERRAN				Joseph E. Kincaid, MD			
EATON				Gary D. Maynard, MD	Χ	X	X
Kory V. Deason, MD	Х	Χ	X	Cecilia M. Prophit, MD		_	_
				Daniel P. Stewart, MD	_		_
GENESEE				Ronald L. VanderLugt, MD	X	Χ	
Ali A. Esfahani, MD		_	_	Geoffrey A. Wardwell, MD	X	_	X
Cyrus Farrehi, MD				Janice L. Werbinski, MD	x	X	X
		_	_		x	x	X
George H. Greidinger, MD				William H. Woodhams, MD	Α	^	Α
Edwin H. Gullekson, MD	X	Χ	X				
Vivian M. Lewis, MD	X	Χ	-	KENT			
Sudarsan Misra, MD	X	Χ	_	John H. Beernink, MD	X		_
AppaRao Mukkamala, MD			_	R. Paul Clodfelder, MD	X	Χ	X
					X	X	/\
W. Archibald Piper, MD				Michelle M. Condon, MD			
Jagdish K. Shah, MD				Patrick J. Droste, MD	_	_	
Robert M. Soderstrom, MD	_	_	_	Douglas A. Edema, MD			
Allen F. Turcke, MD	Χ	Χ	X	Paul O. Farr, MD	X	X	X
Virgil G. Villarreal, MD		X	X	Domenic R. Federico, MD	X	Χ	X
Adb Algharem, MD	Χ	X	_	Gregory J. Forzley, MD	X	X	X
Carlo A. Dall'Olmo, MD	_	X	X	John H. Kopchick, MD	x	X	X
							^
Allan L. Ippolito, MD		X		Rolland D. Mambourg, MD	_		
Kenneth A. Jordan, MD	X	Χ	X	Ann M. Minnema, MD	_	X	X
David Louwsma, DO	X			John P. Papp, MD	X	X	X
Kalyani Misra, MD	X	Χ	_	Sarla Puri, MD	X	X	X
				Jack L. Romence, MD	_	_	_
GOGEBIC				Paul G. Schutt, MD	_		
					_	_	X
Not Represented		_		Anthony J. Senagore, MD		X	^
				David L. Sharp, MD	X	X	X
GRAND TRAVERSE—LEELANAU	J—BENZIE			Peter D. VanVliet, MD	-		_
Robert E. Barnes, Jr., MD	X	X	X	Kathleen J. Yost, MD	X	Χ	X
Edward J. Rutkowski, MD	X	X	X	John M. Curry, MD	X	Χ	X
Richard C. Schultz, MD	x	X	X	Karyn E. Gell, MD	X	X	X
Kichara C. Scholiz, MD	^	^	^		X	X	X
OR IVION				Richard A. Ilka, MD			^
GRATIOT				John R. Maurer, MD	Χ	Х	X
Ashok R. Sonnad, MD	-	_	_	Khan J. Nedd, MD	_	Χ	Χ
				Suresh Puri, MD	X	X	X
HILLSDALE				Jean B. Thomas, MD	X	Χ	X
Andra D. Gelzer, MD	X	Χ	X	Angela R. Tiberio	_	X	X
Allara D. Geizei, MD	^	^	/\			^	X
HALIAHTANI BARAAA WANNI				Francis J. Verde, MD	_		^
HOUGHTON—BARAGA—KEWI				David D. Verdier, MD		Χ	_
Rudy W. Stefancik, MD	X	X	X				
				LAPEER			
HURON				D. V. Ramana, MD	_		_
Helen J. Scoblic, MD				Di Ti Tiannana, Tino			
Heleff J. Scobile, MD				LENIAWEE			
				LENAWEE			
INGHAM				Inad Haddad, MD	X	Χ	Χ
Glen N. Ackerman, MD	Χ	Χ	X	Donald R. Samuel, MD	_	_	_
Don G. Davis, MD	_						
Omero S. lung, MD	Χ	X	Χ	LIVINGSTON			
	X	X	X				
David K. Johnson, MD				Thomas F. Higby, MD	_	_	-
Margaret Z. Jones, MD	Χ	Χ	X				
Donald H. Kuiper, MD		_	_	LUCE			
Edward D. Lanigan, MD	Χ			Not Represented	_	_	_
Brian R. McCardel, MD	X	X	X				
Mithcell A. Rinek, MD	x	X	X	масомв			
J. Wesley Mesko, MD	_	Χ	Χ	Paul R. Gradolph, MD			_
				Ghassan Haurani, MD	_	_	_
IONIA-MONTCALM				Paul R. Kipp, MD	X	X	X
Doyle E. Calley, MD	_	X	X	Joel M. Kriegel, MD	_	Χ	
7.2.2.2.3		.,		Robert R. Peleman, MD	_		_
LOSCO ADENAC						X	X
IOSCO—ARENAC				Ruth A. Rydstedt, MD			^
Devendra K. Sharma, MD	Χ	X	Χ	Milton F. Simmons, MD	X	Χ	X
				Akemi Takekoshi, MD	X	_	X
				Kenneth A. Weinberger, MD	X	Χ	X
ISABELLA—CLARE				Kennem A. Weinberger, MD	/\		
ISABELLA—CLARE Not Represented	_		_		_		
ISABELLA—CLARE Not Represented	_	_	_	Michael H. Piper, MD Samir M. Ragheb, MD	_	x x	X

MANISTEE Vickers C. Hansen, MD X X — NORTH CENTRAL William H. McNamara, MD X <th>***************************************</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>	***************************************								
MARQUETTE—ALGER Carl F. Hammerstrom, MD X <td< td=""><td></td><td>Y</td><td>Y</td><td></td><td>NORTH CENTRAL</td><td></td><td></td><td></td></td<>		Y	Y		NORTH CENTRAL				
MARQUETTE—ALGER Carl F. Hammerstrom, MD	VICKEIS C. FIGHSEH, WID	^	^			X	Х	Χ	
Allan L. Olson, DO	MARQUETTE-ALGER								
Sakthi Vadivel, MD	Carl F. Hammerstrom, MD	Χ			NORTHERN MICHIGAN				
National Strategy Nati	Allan L. Olson, DO	Χ	Χ	X	Bruce G. Deckinga, MD			X	
Richard S. York, MD					Sakthi Vadivel, MD				
MECOSTA—OSCEOLA—LAKE Adoor Amanullah, MD — <th co<="" td=""><td></td><td></td><td></td><td></td><td>Louis R. Zako, MD</td><td>X</td><td>Χ</td><td>X</td></th>	<td></td> <td></td> <td></td> <td></td> <td>Louis R. Zako, MD</td> <td>X</td> <td>Χ</td> <td>X</td>					Louis R. Zako, MD	X	Χ	X
MECOSTA—OSCEOLA—LAKE Jerome A. Conrad, MD ———————————————————————————————————	Richard S. York, MD	Χ	Х	X					
Jaime V. Aragones, MD									
Edward E. Barton, MD					· ·				
Hari G. Chopra, MD	Jerome A. Conrad, MD					X	X	X	
Not Represented					,	-	_		
MIDLAND MIDLAND Mitin C. Doshi, MD Mitin MD Mitin MD Mitin									
Nitin C. Doshi, MD	Not Represented			_		, X		Х	
Gary S. Smith, MD X	AAIDI AAID					_		_	
Robert L. Snyder, DO X X X Peter F. Gordon, MD — X — X Thomas Zuber, MD X		V	V	V		~		~	
MONROE X <td></td> <td></td> <td></td> <td></td> <td></td> <td>^</td> <td></td> <td></td>						^			
MONROE Mark D. Kolins, MD X X X S. R. Nair, MD X		× ×		÷			^		
MONROE Kamalesh Lahiri, MD X X X S. R. Nair, MD X	Inomas Zuber, MD	^	^	^					
S. R. Nair, MD X	MONPOE								
Kenneth J. McNamee, MD X X — Kenneth J. Levin, MD X X — MUSKEGON Robert S. Levine, MD X	***************************************	Υ	Y	Y					
MUSKEGON Murray B. Levin, MD X <t< td=""><td></td><td></td><td>X</td><td>^</td><td></td><td></td><td></td><td>_</td></t<>			X	^				_	
MUSKEGON Robert S. Levine, MD X<	Kermen 3. McMamee, MD	/\	/\						
Frederick B. Brown, MD X X X X — — Stephen E. Fisher, MD X X — — Alan M. Mindlin, MD X	MUSKEGON							X	
Stephen E. Fisher, MD X — Alan M. Mindlin, MD X X X Robert C. Packer, MD X	Frederick B. Brown, MD	Х	X	X		X	Χ		
Robert C. Packer, MD X			_	_		X		X	
A. James Potter, MD — X X George B. Moser, MD X X — Peter T. Muller, MD X X X			X	Х		X	Χ	Χ	
Peter T. Muller, MD X X X	· ·		X		George B. Moser, MD	X			
NEWAYGO Robert C Nestor DO					Peter T. Muller, MD	X	Χ	Χ	
	NEWAYGO				Robert C. Nestor, DO				
James D. Webb, MD X X X Steven E. Newman, MD X X X	James D. Webb, MD	X	X	X	Steven E. Newman, MD	X	X	X	

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EDUCATION AND TRAINING
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Graduate of Highland Park High School
Graduate of University of Michigan Medical School, M.D.
Interpolip Wayne State University Grace Hospital Detry

Member, Michigan State Medical Society

Graduate of Highland Park High School Graduate of University of Michigan Medical School, M.D. - 1969 Internship, Wayne State University, Grace Hospital, Detroit, Michigan Internal Medicine Residency, Henry Ford Hospital, Detroit, Michigan Cardiology Fellowship, Henry Ford Hospital, Detroit, Michigan

PROFESSIONAL

Fellow, American College of Cardiology Fellow, American Heart Association Clinical Associate Professor of Medicine, Wayne State University, Detroit, Michigan Consultant, Biomedical Research, General Motors Corporation (Former) Member, Oakland County Medical Society Member, American Medical Association Former Lecturer, University of Detroit Dental School, Detroit, Michigan Detroit Heart Club, Secretary, Vice President, President President, University of Michigan Medical School Graduating Class, 1969

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	_	_	_	Hassan Amirikia, MD	X	X	X
Renato G. Ramos, MD		_		Lourdes V. Andaya, MD	^	Χ	
James A. Read, MD		~	~	Donald C. Austin, MD			
Jerome F. Rose, MD	X	X	X	Firooz Banooni, MD	X	Χ	Χ
Ghalib Y. Talia, MD	Χ			Edmund M. Barbour, MD	_		
Sherry L. Viola, MD	estronom .		_	David H. Blinkhorn, MD			
Gertraud Wollschlaeger, MD	Χ	X	X	Gilbert B. Bluhm, MD	X	X	Χ
Joseph Arena, Jr., MD	Χ	X	X	Arthur W. Boddie, MD	X	X	X
				Robert G. Borchak, MD	X	X	
OCEANA				R. John Bradfield, MD		_	_
Steven R. Lessens, MD				Kenneth A. Brown, MD	_	_	_
0101011 11. 20000110, 1110				Edward C. Bush, MD	Χ	X	X
ONTONAGON				Arthur M. Clark, MD	X		_
Not Represented	_	_	_	Martin H. Daitch, MD	X	X	X
				Henry M. Domzalski, MD	X	Χ	X
OTTAWA				Chandra M. Edwin, MD	_		
William D. Doebler, MD	Χ	X	X	Samuel J. Edwin, MD	—	_	-
M. Gary Robertson, MD		-	_	John F. Fennessey, MD	Χ	Χ	X
Donald E. Sikkema, MD		_	_	James P. Gallagher, MD	X	Χ	X
William L. VanderVliet, MD	X	X	X	Alma R. George, MD		_	
Theodore S. Vanderveen, MD		X	X	Reginald W. Harnett, MD	X	X	\overline{x}
meddole 3. Vallaelveell, MD		^	^				^
SAGINAW				William A. Harrity, MD	X	_	_
				George C. Hill, MD		X	
Waheed Akbar, MD	_			Cecelia F. Hissong, MD		_	X
Edgar P. Balcueva, MD	Χ	Χ	X	Melwin L. Hollowell, MD	X	Χ	Χ
T. Anthony Egleston, MD	Χ	X	X	Anne-Mare Ice, MD	Χ	Χ	X
Richard P. Heuschele, MD	Χ	X	X	Samuel D. Indenbaum, MD			_
Charles E. Mueller, MD	X	X	X	Dorothy M. Kahkonen, MD	X	X	X
Jacob C. Ninan, MD	Χ	Χ	X	Vijay Khanna, MD	_		_
Conchita D. Riparip, MD	X	X	X	Ronald R. Larson, MD	_	Х	X
Caroline G. M. Scott, MD	X	X	X	Gerald H. Mandell, MD		_	^
Caroline G. M. Scoll, MD	^	^	^				_
CT CLAIR				Anatole C. Matulis, MD	_	_	
ST. CLAIR	.,		.,	Richard Menczer, MD	_	_	_
Timothy Aiken, MD	Χ		X	Kevin M. O'Brien, MD	_		-
James W. Sharpe, MD	_	_		Hanna Obertynski, MD	_	Χ	
John C. Sullivan, MD	Χ		X	Joseph R. Oldford, MD		_	
				Russel F. Proud, MD	X	X	X
ST. JOSEPH				Foster K. Redding, MD	X	X	X
Lawrence R. Werschky, MD				Michele Reid, MD			_
,,				Jan Rival, MD			_
SANILAC				J. Alan Robertson, MD	X	Χ	X
Sosale M. Berkuchel, MD	X		Χ	Rojan Samudrala, MD		_	_
Josale M. Derkocher, MD	^		^	Elizabeth L. Schmitt, MD			_
SCHOOLCRAFT					X	_	X
				Fred R. Severyn, MD		X	
Not Represented	_	_	_	William C. Sharp, MD	_	_	
				Deborah W. Sims, MD			
SHIAWASSEE				Orlando S. Sison, MD	Χ	Χ	_
Timothy D. Oliver, MD	X	X	X	Robert A. Sobel, MD	Χ	Χ	_
				Omer K. Sonbay, MD	_		_
TUSCOLA				Robert A. Songe, MD		Χ	X
Afonso C. Ferreira, MD	X	X	X	Robert A. Teitge, MD	_		
, , , , , , , , , , , , , , , , , , , ,				Arthur A. Ulmer, MD	_	_	
VAN BUREN				Jay Victor, MD	X	Х	
Vincent R. Cabras, MD				Fred W. Whitehouse, MD	x	X	
VIIICEIII K. Cabias, MD		_			_	^	^
WACLIPPALAW				Michael H. Wood, MD	X	_	X
WASHTENAW	V	V	V	Bernard J. Woodley, MD		X	Α
Tama D. Abel, MD	X	X	X	Anthony A. Adeleye, MD	X	X	Χ
Robert L. Bree, MD	_	X	X	Matthew L. Burman, MD	X	Χ	_
Mary B. Durfee, MD		X	X	Linda S. Hotchkiss, MD	X	_	
Karl J. Edelmann, MD			-	James E. Kackley, MD	_	Χ	
Carl M. Frye, MD	X	X	X	E. Michael Krieg, MD	Χ	X	X
David W. Learned, MD	_	Χ	X	Robert P. Lilly, MD	Χ	Χ	
Manfred Marcus, MD	_	_		Ghaus M. Malik, MD	X	Χ	_
John M. O'Brien, MD	X	X	Χ	Kamran S. Moghissi, MD	X	X	
Diana M. Rothman, MD		_		Michael A. Sandler, MD	x	x	Y
	X	X	X	Narinder K. Sherma, MD	x	x	Y
Marguerite R. Shearer, MD							^
Michael W. Smith, MD	X	X	X	Gary B. Talpos, MD	Χ	Χ	
L. Paul Sonda, III, MD		X					
Carl Van Appledorn, MD	X	X	X	WEXFORD—MISSAUKEE			
Scott W. Woods, MD	X	X	X	Sandra Blanchard, MD	X	X	Χ
C. Peter Fischer, MD		Χ	_				
Edward R. Powsner, MD		X	X	MDPH Chief Medical Officer			
				David R. Johnson, MD, MPH	_	Χ	Χ
WAYNE							,,
	X	X	X	IMMEDIATE PAST PRESIDENT			
Susan H. Adelman, MD Antonio A. Aguirre, MD	X	X	X	IMMEDIATE PAST PRESIDENT Jack L. Barry, MD	X	X	Χ

MEDICAL SCHOOL DEANS Robert J. Sokol, MD, WSU		_	_	MI SECTION — AMERICAN COLLEG	GE OF OI	3STETRICS	S AN
Giles G. Bole, MD, UM		olytomolijiyota	_	Not Represented	_	-	_
William H. Abbott, PhDm MSU		_	_				
MEDICAL STUDENT SECTION				MI OCCUPATIONAL AND ENVIRON ASSOCIATION	NMENTA	L MEDICA	AL.
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mily Smith	X	-	X				
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AICHIGAN STATE UNIVERSITY				Paul P. Fecko, MD	_	_	-
VAYNE STATE UNIVERSITY				MI ORTHOPAEDIC SOCIETY			
ee S. Benjamin	Χ	Χ	Χ	Kenneth S. Merriman, MD	Χ	Χ	Χ
OSPITAL MEDICAL STAFF SECTION				MI OTOLARYNGOLOGICAL SOCIE	TY		
hn A. Rupke, MD	Χ	Х	Χ	Not Represented	_	_	_
OUNG PHYSICIANS SECTION				MI SOCIETY OF PATHOLOGISTS			
eter S. Chang, MD	Χ	Χ	X	Donald R. Peven, MD	X	Χ	Х
ior o. Chang, MD	^	^	^	Donard R. Feven, IVID	^	^	^
ESIDENT PHYSICIAN SECTION				MI CHAPTER — AMERICAN ACADE	MY OF P	EDIATRIC	S
nilip J. Boyer, MD, PhD	X	X	Χ	Irving M. Miller, MD	_	Χ	Χ
ECTION FOR INTERNATIONAL A	MEDICAL (MI SECTION OF CLINICAL PHARM	ACOLOG	Y &	
an C. D. Brown, MD	-	X	Χ	THERAPEUTICS			
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PECIALTY SOCIETY ORGA	ANIZATI	ION2		MI CHAPTER — AMERICAN COLLEG	GE OF PI	HYSICIAN	5
				Raymond H. Murrary, MD	_		_
ALLERGY AND ASTHMA SOCI	ETY						
mes H. Saker, MD	_	X	Χ	MI ACADEMY OF PHYSICAL MEDIC	INE AND)	
				REHABILITATION			
SOCIETY OF ANESTHESIOLOG	SISTS			Michael T. Andary, MD	-	_	******
vid M. Krhovsky, MD	_	X	Χ	MI ACADEMY OF PLASTIC SURGEO	NS		
CHAPTER — AMERICAN COLL	EGE OF C	HEST		Vigen B. Darian, MD	_	Χ	Х
TYSICIANS	LGE OF C	11631		and the state of t		, ,	,,
bert E. Klimek, MD	-	_	-	MI PSYCHIATRIC SOCIETY			
				Not Represented			_
SOCIETY OF COLON AND REC	TAL SURG	SERY		MI PSYCHOANALYTIC SOCIETY			
artin A. Luchtefeld, MD	_	_	-	Evangeline J. Spindler, MD	Χ		Х
I DERMATOLOGICAL SOCIETY				Evangenne 3. Spindler, MD	^		^
ichael A. Dorman, MD	Χ	Χ	X	MI ASSOCIATION OF PUBLIC HEAD	LTH PHYS	SICIANS	
and in a comman, me		,	^	John R. Petrasky, MD	Χ	Χ	Χ
CHAPTER - AMERICAN COLL	EGE OF E	MERGEN	CY				
YSICIANS				MI RADIOLOGICAL SOCIETY	V	V	
regory L. Walker, MD	-	X	Χ	Thomas C. Payne, MD	Χ	X	Χ
	LANG			MI RHEUMATISM SOCIETY			
ACADEMY OF FAMILY PHYSIC ary E. Roth, MD	X	Χ		Not Represented	_		No.
ary E. Kom, MD	^	^					
SOCIETY OF GASTROINTESTIN	NAL END	OSCOPY		MI SLEEP DISORDERS ASSOCIATION	N		
ot Represented	_	_	_	Not Represented	-		_
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SOCIETY OF GENERAL SURGE				MI SOCIETY OF THERAPEUTIC RAD Not Represented	HOLOGIS	313	
enald C. Camp, MD	Х	_	_	Not Represented	_		-
SOCIETY OF INFECTIOUS DISE	FASE			MI CHAPTER — AMERICAN COLLEG	GE OF SU	JRGEONS	;
Represented		concre	_	Larry R. Lloyd, MD	-	_	_
SOCIETY OF INTERNAL MEDIC				MI SOCIETY OF THORACIC AND			
nn P. Papp, MD	X	X	X	CARDIOVASCULAR SURGEONS	V	Х	V
ACCOCIATION OF MEDICAL	VALIETE-			Allen Silbergleit, MD	Χ	٨	Χ
ASSOCIATION OF MEDICAL E	XAMINER X	2 S X	X	MI THORACIC SOCIETY			
siilis A. Siiidilwood, DO	^	^	^	Robert E. Klimek, MD			
ASSOCIATION OF NEUROLOG	SICAL SUI	RGEONS					
ot Represented	_	_	_	MI UROLOGICAL SOCIETY			
·				Ray Littleton, MD	_	_	_
NEUROLOGICAL ASSOCIATIO				MI VASCIJI AD SOCIETY			
even E. Newman, MD	X	X	Χ	MI VASCULAR SOCIETY Frederick W. Sherrin, MD			
COLLEGE OF NUCLEAR MEDIC	TIME DUY	SIGIANIS		Carlo A. Dall'Olmo, MD	_	X	X
of Represented	JINE PHY	SICIANS		Canori, Dan Ollio, MD		, ,	
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EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

August

6, 13, Bar-Levav Education Association Ongoing Seminar Series "The Patient/Physician relationship revisited: What's in it for the doctor?" Location: Bar-Levay Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa. DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

8-10, Third Annual Symposium on Biomedical, Biopharmaceutical, and Clinical Applications of Capillary Electrophoresis. Location: Leighton Auditorium, Siebens Building, Mayo Clinic, Rochester, MN. Contact: Postgraduate Courses, Section of International Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: 800-323-2688. Fax: 507-284-0532.

18-20, Success with Failure: New Strategies for the Evaluation and Treatment of Congestive Heart Failure. Location: Vail Cascade Hotel, Vail, Colorado. Contact: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First St., S. W., Rochester, MN 55905. Phone: 1-800-323-2688. Fax: (507) 284-0532.

20, 27, Bar-Levay Education Association Ongoing Seminar Series "Overcoming difficulties in the psychotherapeutic alliance." Location: Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration

September

3, 10, Bar-Levay Education Association Ongoing Seminar Series "Working through real losses in patients' lives." Location: Bar-Levay Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

14, 17, Bar-Levav Education Association Ongoing Seminar Series "The therapist's character and its impact on the patient." Location: Bar-Levay Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration

19, The Clinical Determination of Disability for Social Security: Continuing Medical Education Conference, Location: Van Dyke Park Hotel and Conference Center. Warren, Michigan. Sponsors: The Michigan Department of Social Services, Michigan State University College of Human Medicine and College of Osteopathic Medicine. Contact: Carrie Dunkle (313) 256-2375.

October

1, 8, 15, Bar-Levay Education Association Ongoing Seminar Series "The therapist's character and its impact on the patient." Location: Bar-Levay Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

14-16, 1196 International Meeting on ANCA and ANCA-Related Diseases, The 7th International ANCA Workshop, Location: Phillips Hall, Siebens Building, Mayo Clinic, Rochester, Minnesota. Sponsor: Mayo Foundation. Contact: Postgraduate Courses, Section of International Medical Education, Mayo Foundation, Rochester, MN 55905, 1 (800) 323-2688 or (507) 284-8399; Fax (507) 284-0532

22, 29, Bar-Levav Education Association Ongoing Seminar Series "When is a change of psychotherapists clinically indicated." Location: Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

25-27, Advances in Sonography; Fifth Annual Meeting and Postgraduate Educational Course. Location: The Fairmont Hotel, San Francisco, CA. Sponsor: Society of

EDUCATIONAL OPPORTUNITIES

Radiologists in Utlrasound. Contact: SRU office, 1101 Market Street, 14th Floor, Philadelphia, PA 19107 (215) 574-3183; Fax (215) 923-1737; Email sru@acr.org.

November

5, 12, Bar-Levav Education Association Ongoing Seminar Series "The future of psychotherapy." Location: Bar-Levav Educational Association, 3000 Town Center,

Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

14-16, MSMS Annual Scientific Meeting Location: Lansing Center, Lansing. Contact: Sarah Cressman at (517) 336-5727. Approved for:

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ONGOING

Case Studies in Environmental Medicine. Location: Your office/home (self-instructional monographs). Sponsor: The Agency for Toxic Substances and Disease Registry, Division of Health Education. Contact: Michele Borgialli, Michigan Department of Public Health, Division of Health Risk Assessment, P.O. Box 30195, Lansing, MI 48909, (517) 335-9647. Approved for: Up to 33 hours of free Category I Credits; 1 per case study.

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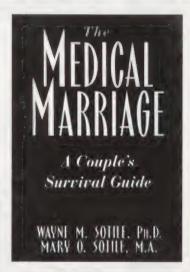
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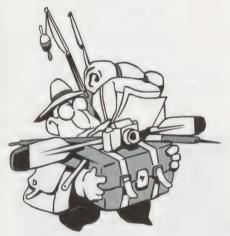
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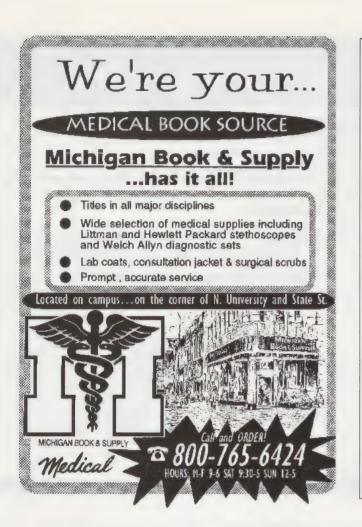


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SIGN OF THE TIMES



With younger delegates attending MSMS Annual Meetings, and with their strong emphasis on the family, the photographer caught this scene in the waning minutes of the 1996 MSMS House of Delegates. Seated with his daughters is Midland County Delegate Thomas Zuber, MD.

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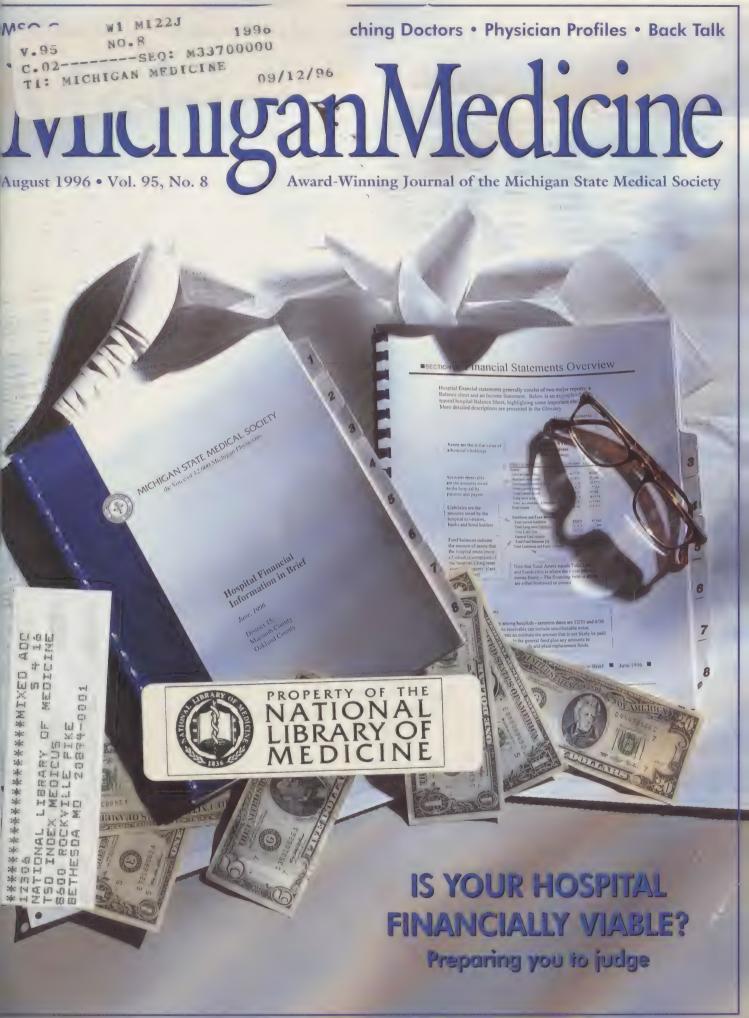
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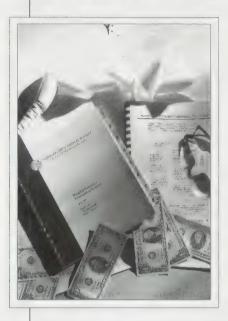
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COVER STORY



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MSMS takes another bold step to put member physicians in the driver's seat of medical care changes. Our cover story previews this next step, which will empower Michigan physicians to determine their hospital's financial viability. Determining your hospital's future enables you to determine your own future. The August issue gives you the tools to analyze your own hospital's status; MSMS will follow with the actual financial statistics in October.

Cover photo by: Roger Hill

FEATURES

PRACTICE MANAGEMENT

MSO Case Study Provides Insights

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MSMS, the AMA and other partners set out to learn from successful physicians' management services organizations across the country. Those lessons learned will help as MSMS builds its own MSO. By William E. Madigan

MSMS ALLIANCE

Charting a course for a successful year

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Excerpts from the President's installation address by Janet Gregory

PUBLIC HEALTH

Michigan Children's Immunization Registry

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An important tool in improving immunization rates among two-year-olds is coming this fall. By James K. Haveman, Jr.

PHOTO FEATURE

Members meet legislators at MSMS Capitol Check-Up

30

MSMS, the MSMS Alliance and the Michigan Medical Group Managers Association gather for a day of grassroots legislative training and meetings with local legislators.

Photos by Pattrick Yockey



August 1996 Volume 95, Number 8

MSMS Internet E-mail Address: http://www.msms.org/

MEDICAL ECONOMICS New Medicare Rules New rules mean teaching physicians will have to document when resident or clinical fellow is involved in a patient's care By Karen Bouffard
PHYSICIAN PROFILE W. Peter McCabe, MD 1996-97 MSMS president views leadership as fulfillment of responsibility as physician By Karen Bouffard 42
LIFE'S PLEASURES Going for the Gold Northern Michigan physician John Lehtinen, MD, was lead physician for the US Olympic Team By William Kendy
PHOTO FEATURE Highlights of Regional Scientific Meeting Attendees discuss future physicians, new immunization vaccines and women's health issues Photos by Pattrick Yockey 51
OFF DUTY The Pathologist Who Would Be President Michael Barbarich, MD, of Escanaba, is nominated for the presidency of Bosnia-Herzegovina in elections scheduled September 14. This improbable tale is equal to an action/adventure movie. By Ralph D. Ward

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LETTERS



Members respond to MSMS contacts

MSMS currently is engaged in a campaign to personally contact by mail and phone as many MSMS members as possible. The purpose is to thank these members for their MSMS participation and to ask how MSMS might serve members better. Following are some recent responses to the campaign.

"Thank you so kindly for your personal note and for your efforts on behalf of the Michigan State Medical Society. It is quite apparent to me and to so many others in the American Medical Association Federation that the Michigan State Medical Society is a flagship member with a great history to be proud of. It seems to me that our present status may be the best ever. Keep up the good work."

Joseph A. Rutz, Jr., MD, FACOG Okemos, MI

If you would like to comment on an article in Michigan Medicine, or any other aspect of the magazine, please contact Judy Marr, manager, Communications and Professional Relations, at (517) 336-5744, or by FAX at (517) 337-2490, or E-mail at imarr@msms.org

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"I loved the note you sent, I appreciate the personal touch! I truly appreciate all that MSMS staff does for me. I read all your materials - especially Michigan Medicine and Medigram."

MSMS is doing a fine job.

Lawrence F. Handler, MD Clinton Township, MI

Thank you for plan evaluation

Several months ago, you sent me a copy of Michigan State Medical Society's Evaluation of Michigan Health Plans. I greatly appreciate receiving this "first-ever" medical society review of Michigan Health Plans. I believe that having such comprehensive vital information about health plans available is a valuable service which the MSMS can provide. Information such as this is critical as federal legislators begin to respond to the issues that stem from the increasing number of Americans enrolled in some form of managed care. Thank you for making this available to me and my staff.

The Hon. John D. Dingell Michigan Congressional Delegation

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Question:

What is the funniest thing a batient ever said to you?

66 I was examining a ninemonth-old baby, and I asked the mom if the baby was saying any words yet. She said, 'Well, I was

feeding him some oatmeal which was too hot, and the baby said, "I can't believe that you gave that to me." I tried to keep very straight faced and asked her about it some more. She explained, 'His father is a genius you know.' Nothing ever developed from this, so apparently it was just an isolated stroke of genius."

Linda S. Evans, MD, 47

Pediatrician, River Country Pediatrics, Three Rivers

We had a patient who was diagnosed with herpes. We were questioning her about how she may have gotten it, and she said, 'I was frying bacon in the nude, and got spattered with some grease. Could that have caused the blisters?""

John R. Clark, MD, 40 OBGYN, Sturgis

This is a story from the 1920's, which was told to me by an older colleague when he was on his deathbed.

He was called out to a farm in the middle of the night to take care of a farmer who had a head injury. There wasn't much the doctor could do, so he told the wife to pack the farmer's head in ice and he'd be back in the morning. Next morning, he called an ambulance. The farmer looked so bad the ambulance driver said, 'How about if I just park behind the barn for a few minutes. It'll save us the trip.' The doctor prevailed, and the patient was taken to Ann Arbor Hospital, where he went into surgery.

In the 1920's, there was no anesthesiologist, and that kind of operation was done with the patient sitting up and draped. The surgeon asked the family physician to assist. About two-thirds of the way through the operation, the surgeon asked my friend to take a look at the patient and see how he was doing. The family doc crouched down, lifted up the drape and got under it so he could take a look. When he did, the patient opened his eves and said, 'Doc, where the hell am I?'

Apparently, the surgeon had relieved the pressure on the brain, and with no anesthesia the patient just woke up. The farmer went on to live a long healthy life."

John Girardot, MD, 66

General Surgeon, Battle Creek

^{€6}A young girl was in for her annual physical and I asked her about her methods of birth control. She told me not to worry because she was using condominiums."

Harry Holwerda, MD, 56

Family Practice, Grand Rapids

My first practice was in an old house. We had added a middle room with a door that didn't reach quite to the floor, so just by looking under we could see if anybody was in the room. Once, we checked all the rooms to be sure everyone had left and went home for the night. That night, I got a call from one of my patients. He said, 'Hey doc, did'ya forget about me?' The patient had fallen asleep on the exam table. When he woke up, he went home and gave me a call."

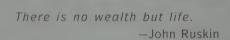
Virginia K. Brown, DO, 59 Family Physician, Riverview

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HEALTH INSURANCE FOR SCHOOL EMPLOYEES

Is it legal to waive patient co-pays and deductibles?

By Richard D. Weber, MSMS Legal Counsel



Q: Is it illegal for a physician to discount a patient's fee or otherwise waive a patient's copay or deductible under an insurance policy?

A: Absent a provision to the contrary in a participating physician insurance agreement, there is no law that precludes a physician from discounting or waiving fees. In fact, this is encouraged in instances of patient financial hardship.

Physicians should be aware that forgiveness or waiver of co-payments or deductibles may violate the policies of some insurers. By imposing co-payments or deductibles, insurers attempt to discourage unnecessary health care. To the extent a physician has agreed to participate in a health insurance program and has therefore assumed certain contractual obligations, the physician should make sure that there are no contractual provisions against such discounting or waiving of co-pays or deductibles. If such a provision exists, the practice of waiving fees could be deemed to be a breach of contract.

Even if a participation agreement has no provision against discounting or waiving co-pays or deductibles, the submission of a claim for payment to the insurer could form the basis of a violation of the Michigan Health Care False Claim Act. This Act makes it illegal for a person to make a claim for benefits to a health care corporation

or insurer which that person knows to be false. The Act defines "false" to mean wholly or partially untrue or deceptive. It defines "deceptive" to mean making a claim to a health care corporation or health care insurer which contains a statement of fact or which fails to reveal a material fact, and which leads the health care corporation or insurer to believe the represented or suggested state of affairs to be other than it actually is. Waiving or discounting a patient co-pay without disclosing this fact could fit the definition of a false claim under the Act. It could be argued that the physician failed to reveal the material fact that he/she did not charge the patient as much for the services as was represented to the insurance company and, therefore, the claim was "deceptive" and "false" under the Act. Although there are no appellate court decisions in Michigan interpreting the Act in this factual context, the practice of waiving or discounting the patient's co-pay without disclosure to the insurer could be deemed a violation of the Act. Physicians should make sure that there is no misrepresentation in an insurance billing statement which either states a fact or fails to reveal a material fact which results in a misrepresentation to the insurer or managed care organization. To avoid this possibility, it is recommended that any waiver or discount be reflected in the insurance statement so as to avoid this potential statutory violation.

Under the Medicare fraud and abuse laws, the HHS Office of Inspector General has taken the position that "routine waiver" of Medicare co-payments and deductibles is unlawful because it results in false claims, violations of the Medicare anti-kickback statute and excessive utilization of services paid by Medicare. HHS has asserted that providers who routinely waive Medicare co-payments and deductibles are subject to criminal, civil and administrative liability for submitting false claims to Medicare. Medicare recognizes a "hardship exception," but provides no definitive guidelines as to the application of the rule against routine waiver of Medicare co-payments and deductibles.

Editor's Note: If you have legal questions you would like answered by MSMS legal counsel in this column, jot them down and send them to Judith Marr, manager, Communications and Professional Relations, P.O.Box 950, East Lansing, MI 48826-0950.

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Via e-mail, you may subscribe to news sources on the Internet by placing your e-mail address on a mailing list. There is usually no charge for this subscription service, and topics covered range from the latest medical breakthroughs to information on hot fishing spots in Michigan. A comprehensive list of medical mailing lists on the Internet is available at http://kernighan. imc.akh-wien.ac.at/stz/plattner/ all.htm

On the World Wide Web, several sites are dedicated to providing updated news content to Internet users. Using the protocols afforded by the Internet, you can browse a condensed copy of today's New York Times at http://www.nytimefax.com. view the latest in U.S. and international news at http://www.cnn.com. or listen to a live radio newscast us-RealAudio at http:// www.ktrt.com/frame2.html

Usenet news is a network of computers that distributes news items and discussion groups around the world. Articles on over 14,000 subjects can be read and commented on, adding your opinion to the international mix of ideas. To get to Usenet news through Netscape enter news: in the Location field of the browser.

Windows 95 and the Internet

As the first anniversary of the Windows 95 introduction approaches, it is clear the impact of the operating system has been most profound on Internet users. Windows 95 provides tools for accessing documents and information on the Internet.

By employing Dial - Up Networking, Windows 95 users can establish a PPP connection to the Internet quickly and easily. This connection is integrated into the base of operating system, meaning this kind of connection is faster and more stable. Instructions for using Windows 95 to connect to the Internet through Voyager and MSMSNET are available at http://www.voyager.net/welcome/win95.html.

Microsoft Exchange, also available through Windows 95, offers new, richer formatting options, including bold, italic, and underlined fonts, as well as different font sizes and types. In addition, you can imbed sounds, pictures, and movies in messages, which can be viewed by your mail's recipients.

The Windows 95 Plus pack includes Internet Explorer 1.0, a web - browser that serves as a nice alternative to Netscape. Later versions of Internet Explorer are available for free at Microsoft's homepage at http://www.microsoft.com.

Find us on-line at http://www.msms.org/

"Surfing the Internet" is a monthly feature of Michigan Medicine. If you MSMSNET, or Voyager Information DeCourcy at MSMS via E-mail at bdecourcy@msms. org or by phone

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MSO case study provides insights for Michigan MDs

By William E. Madigan

I ow do you build a successful physicians' management services organization? MSMS, the AMA and several other medical societies set out a few months ago to learn the answers to this question. What we learned will have important ramifications for the MSO the MSMS House of Delegates has directed your state society to create. The House of Delegates believes your own MSO will provide you with the best possible services and support as you, our members, move toward success in the managed care arena.

in states like California that prohibit the corporate practice of medicine). In other cases, MSOs offer services to networks of independent physicians. In most cases, MSOs use a combination of these approaches. In selecting organizations for

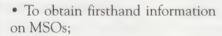
of the MSO (or of a foundation

inclusion in the study, we attempted to include a crosssection of MSOs, based on such factors as MSO ownership, geographic location and services

offered. Based on these and other factors, the following seven MSOs were selected for inclusion in the study:

- Bonaventure Medical Foundation (Itasca, Illnois)
- Carolina Atlantic MSO (Charleston, SC)
- CHS Management (Los Angeles, CA)
- HealthCap (San Diego, CA)
- Managed Care Systems (Sacramento, CA)
- MedPartners/Mullikin (Birmingham, AL)
- PennMed Service Corporation (Harrisburg, PA)

Over the past several months, MSMS, along with the AMA and four other state and specialty medical societies, conducted a case study of management services organizations (MSOs) throughout the United States. The study, which examined seven MSOs, had the following goals:



• To identify key strategic and operational issues:

• To develop an understanding of MSO success factors; and

 To disseminate information to assist physicians in developing viable managed care strategies,

The study sponsors recognize that there is no commonly accepted definition of an MSO. As a result, in undertaking the study, the sponsors viewed the MSO model in its broadest sense as "an entity that is owned by physicians, hospitals, private investors or a combination thereof, which provides contract management and/or practice management services to physicians and medical groups." In some cases, MSOs purchase the hard assets of medical practices (e.g., medical equipment, office furniture and supplies) and the physicians and other office staff become employees

As with the PO and PHO case studies conducted in the past two years by the AMA, MSMS and partner medical societies, one-day site visits were conducted at each organization, which involved meetings with board and committee members, administrative staff and physician leaders.

The resulting report is organized into two major sections. The first section addresses major MSO issues and draws upon the insights gained throughout the series of site visits. This section provides a summary of the most significant issues, findings and conclusions that arose from the study and illustrates how particular issues, such as capitalization or contracting have been addressed by different MSOs. The second section



of the report, which consists of detailed information on an MSO-by-MSO basis, provides a more in-depth analysis of the organizational structure and operations of each MSO included in the study.

The case study resulted in the following 15 key findings:

- 1. MSOs typically provide a blend of contract management and practice management services designed to maximize the efficiency and productivity of physician practices.
- 2. Substantial capital is required to develop and operate a successful MSO.
- 3. MSO development should be driven by a clear organizational vision and a strong business plan.
- 4. MSOs must have a sound administrative infrastructure, with qualified, experienced support staff.
- 5. There must be an appropriate balance of physician, administrative and other interests in MSO governance.
- 6. MSOs must be proactive and willing to assume risk.
- 7. Most MSOs recognize the value of both IPAs and medical groups and, therefore, are incorporating both models into their longterm strategies.
- 8. MSOs are pursuing aggressive geographic expansion strategies which require them to be able to manage the delivery of medical care from a distance.
- 9. Most MSOs are pursuing strategic partnerships with payers and hospitals based on a "win-win" philosophy.
- 10. MSOs are focusing on providing services that relate to their core competencies and, by and large, are rejecting the option of forming their own HMOs.
- 11. MSOs are actively involved in quality management.

- 12. Because management of utilization is critical to the success of MSOs, most MSOs have implemented active utilization management programs.
- 13. MSO contracting efforts are clearly directed toward accepting greater levels of risk, by assuming responsibility for a larger portion of the premium dollar.
- 14. Physicians employed in MSO groups are usually compensated through some combination of salary and financial incentives, while IPA physicians are paid on either a fee-for-service or capitation basis.
- 15. MSOs recognize the importance of information systems to their future success and are working to implement systems to meet their needs-but none feels that their systems are adequate at the present time.

MSMS will use the "lessons learned" from the MSO case study in developing our MSO subsidiary.

Currently, MSMS is writing the business plan for our MSO, and will be holding a series of briefings in September to update MSMS members on our progress to date. For additional information concerning the briefings, please call Mary Anne Ford at (517) 336-5721. ■

William E. Madigan is executive director of the Michigan State Medical Society.

Copies of the complete case study are available from MSMS for \$25 for members of MSMS, the AMA, the Michigan Medical Group Managers Association or the Michigan Association of Osteopathic Physicians and Surgeons. The report is available to non-members for \$95. Please contact MSMS at 517-336-7594 if you are interested in burchasing a copy of the study.

Case Study

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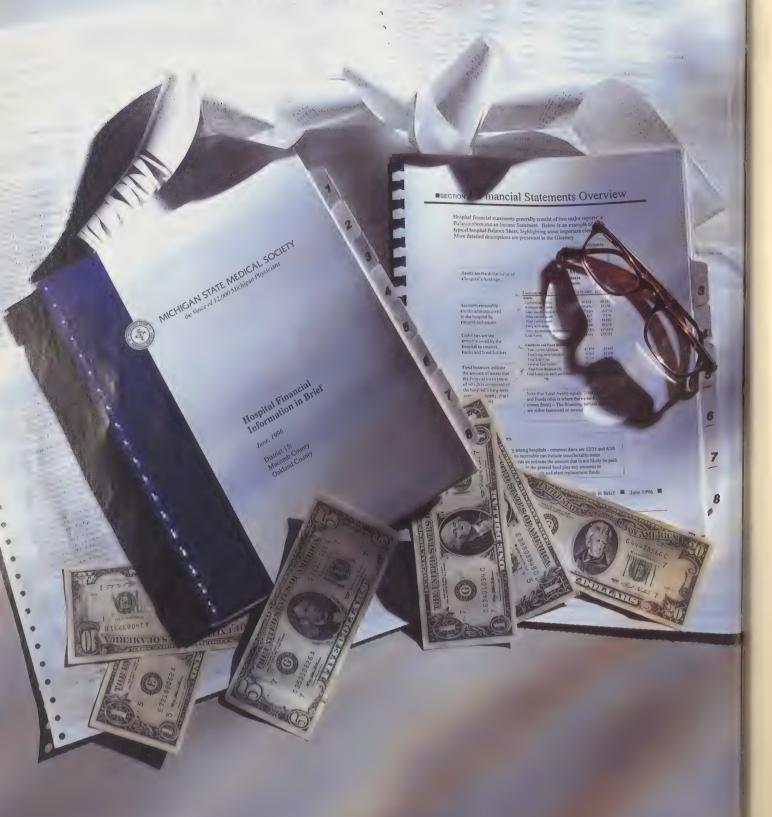
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nformation is power. Empowering Michigan physicians to give them the best possible shot at a positive, rewarding, successful future is the number one MSMS mission.

With that goal in mind, MSMS has once again taken a bold step to provide Michigan physicians with the information they need to give them power—power to make choices, to negotiate, to select the career and personal paths they decide are most to their benefit.

This month's Michigan Medicine cover story previews the latest information MSMS has gathered for members' benefit, and provides you with the tools to analyze the data MSMS will release in October.

Hospital Financial Information in Brief

re you aligned with a financially stable hospital? Approximately six months ago, MSMS set out to gather the figures that would help you answer that question so vitally important to your future. The data are coming in, and the MSMS report will be released in September.

A draft copy of the first MSMS report on "Hospital Financial Information In Brief," produced this summer, went to the MSMS Board at its midsummer meeting July 12-13 in Gaylord, and has been shared with selected hospital presidents. The draft includes a review of hospital financial information from 17 hospitals in Oakland and Macomb Counties. Guides for understanding the draft are printed in this issue, to give members help in analyzing the data when it is released. A report on all hospitals in Michigan will be completed by October.

This is a project first proposed by the MSMS Organized Medical Staff Section. The goal is to give physicians a clear picture of the financial condition of the various hospitals with which they are, or may become, affiliated. Members may order a copy of this and future reports through MSMS.

MSMS believes community hospitals, with their varying missions, management philosophies and operational goals, are an increasingly integral element in a physician's business relationships with many organizations.

Information in this and coming reports will be vital to physicians making decisions about contracting with one or more hospitals, POs, HMOs, PPOs, merging medical practices', joint venturing with a management services organization or selling their practices to a hospital.

The information in this report came from publicly available data collected in Medicare Cost Reports. The data is be-

ing analyzed and synthesized to provide hospital financial information "in brief."

"In brief" is emphasized for a number of reasons. First, due to space limitations, only the most basic financial information will be presented in this report. The report will contain indicators to assist readers in interpreting the basic hospital financial statements including balance sheets, income statements and the coordination of this information with general statistics.

Second, the presentation of information in Medicare Cost Report follows a standardized format, one that does not necessarily provide a complete picture of a particular hospital's financial status.

Third, financial statements cover specific periods of time. Events before or after a reporting date may be reflected in the notes to financial statement, but will not appear in a simple examination of the numbers.

And finally, detailed information on hospitals' relationships with other organizations, contracts with payers and other strategic information does not fit neatly into tables of numbers, but may be the most important indicators of future financial viability. Physicians with needs for more detailed information on their hospitals' finances should be in contact with their hospital's financial staff.

For assistance in analyzing the forthcoming MSMS Hospital Financials Report, and for interpreting the data to empower you to make future plans, please contact F. B. "Tom" Plasman at MSMS headquarters, 517/336-5724, fax him at 517/337-2490, or e-mail him at tplasman@msms.org.

Following are a few of the financial indicators in the forthcoming MSMS report which reveal the financial status of each hospital:

Days Cash on Hand Days Accounts Receivable Average Age of Assets

Fund Balance
Equity Financing Ratio Revenue Per Admission
Operating Expense Per Admission
Operating Income Per Admission
Reimbursement to Change Ratio
Operating Margin



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The impact of the MSMS hospital financials study

Michigan Medicine asked several key persons to assess the importance of the study MSMS is just completing on Michigan hospital's financial status. Here are some of their comments:

Peter A. Duhamel, MD MSMS President-elect

This first MSMS hospital financial information report profiles many hospitals in Oakland and Macomb counties with which I have some degree of familiarity. The report also does a good job of explaining to the non-accountants among us how to read a financial statement and how these numbers may or may not be compared among the various institutions. Understandably, some of the hospitals' reports are incomplete and some have very little data. However, I feel this is a good first step to educate physicians about the financial status of hospitals with which they relate. It also may help them form in their minds the questions which need to be asked of these hospitals.

Kevin Cawley Chief, Michigan Medical Advantage (MSMS MSO)

The forthcoming MSMS survey of hospitals will provide valuable insight for physicians throughout the state for a variety of purposes. Most importantly, the document inclues specific institution-by-institution data that any physician who works with, works for, or competes with a hospital needs to know.

For evaluating the financial viability of competing institutions, this is the scorecard. For an employed physician it's a chance to compare seaworthiness with other organizations. For those ready to pursue capitation, it offers the chance to size up vendors and competitors. In short, this is the type of information that any physician who has a relationship with a hospital will want to monitor.

John "Kevin" Sullivan, MD Medical Director Port Huron Hospital

In an era of increasing managed care, and diminishing reimbursement to providers, it is critical that physicians not only understand the financial position of their practices but also the financial position of hospitals where they admit patients. This is particularly important in smaller communities with one hospital or when physicians through POs, PHOs, PSOs or MSOs are entering into business relationships with hospitals.

The first hurdle is for physicians to understand the hospital's balance sheets, income statements and other indicators of long-term financial viability. Only by understanding your hospital's financial viability can you make plans for your own practice and for your patients. The MSMS hospital financial information is an excellent introduction to the financial side of the hospital business.

"The doctor said Bayer discovered the medicine in my Adalat CC twenty years ago!

Guess he didn't switch me from Procardia XL®* just to save me money."



The People Who Discovered Nifedipine

Once-A-Day



30mg, 60mg & 90mg

Real Value for Real People with Hypertension

In 1972, Bayer scientists discovered nifedipine. Foday, the Adalat® brand of nifedipine is available from Bayer in several formulations around the world.

In the United States, the one to prescribe is Adalat® CC. And thousands of physicians have been doing just that—more than 10 million prescriptions have been dispensed since its introduction in 1993.¹

Blood pressure reduction provided by Adalat CC is comparable with Procardia XL.^{2,2,3} The frequency and type of side effects reported with Adalat CC are typical of dihydropyridine calcium channel blockers.⁴

Adalat CC is not indicated for angina. It should be taken on an empty stomach. As with all distinct pharmacologic entities,

switching from one to another may necessitate careful titration and patient monitoring.

The pricing differential remains—initial doses of Adalat CC are 29% less than the Average Wholesale Price (AWP) for Procardia XL.⁺⁵

Adalat CC from **Bayer**.

People are spreading the word.

Please see next page for a brief summary of Prescribing Information.

^{*}Procardia XL (nifedipine) is a registered trademark of Pfizer Labs Division, Pfizer Inc.

[†]Calculations based on suggested Average Wholesale Price (AWP).⁵ AWP is from a published price list and may or may not represent the actual price to pharmacists or consumers.

From Bayer

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Once-A-Day



30mg, 60mg & 90mg

Real Value for Real People with Hypertension

BRIEF SUMMARY
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INFORMATION

INDICATION AND USAGE: ADALAT CC is indicated for the treatment of hyperten-It may be used alone or in combination with other antihyperte CONTRAINDICATIONS: Known hypersensitivity to nifedipine.

WARNINGS: Excessive Hypotension: Although it most potients the hypotensive effect of nifedipine is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial fittration or at the time of subsequent upward dosage adjustment, and may be more likely in patients using concomitant beta-blockers.

likely in patients using concomitant belra-blockers. Severe hypotension and/or increased fluid volume requirements have been reported in patients who received immediate release capsules together with a beta-blocking agent and who underwent coronary artery bypass surgery using high dose fentanyl anosition sia. The interaction with high dose fentanyl appears to be due to the combination of infectipien and a beta-blocker, but the possibility that it may occur with nifedipien alone, with low doses of fentanyl, in other surgical procedures, or with other narrotic analyses cannot be ruled out. In nifedipine-treated patients where surgery using high dose fentanty anesthesia is contemplated, the physician should be owner of these potential problems and, if the patients condition permits, sufficient time (or least 36 hours) should be allowed for nifedipine to be weshed out of the body prior to surgery.

snown ac anowen or innounter to be washed out or the abody prior to surgery.

Harcreased Angine and/or Myocardial Infarctions: Rarely, potients, porticularly those who have severe obstructive coronary artery disease, have developed well documented increased frequency, duration and/or severity of angina or acute myocardial infarction upon starting nifedipine or at the time of dosage increase. The mechanism of this effect is not established.

Bate-Blocker Withdrawae. When discontinuing a beta-blocker it is important to taper its dase, if possible, rather than stopping abruptly before beginning nifedipine. Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angino, probably related to increased sensitivity to catecholomines. Initiation of infedipine treatment will not prevent this occurrence and on occasion has been reported to increase it. Congastive Heart Failure: Rarely, patients (usually while receiving a beta-blocker) have developed heart failure after beginning nifedipine. Patients with tight cortic stenosis may be at greater risk for such an event, as the unloading effect of nifedipine would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the cortic valve.

PRECAUTIONS: General - Hypotension: Bocause nifedipine decreases peripheral vas-cular resistance, careful monitoring of blood pressure during the initial administration and triardion of ADALAT CC is suggested. Close observation is especially recommended for patients already toking medications that are known to lower blood pressure (See WARNINGS).

otreody facing medications that are known to lower blood pressure (see WARMINGS). Peripheral Edemics: Mild to moderate peripheral elema occurs in a doss-dependent manner with ADALAT CC. The placebo subtracted rate is approximately 8% at 30 mg, 12% at 60 mg and 19% at 90 mg daily. This eleman is a locatice of heromenon, hought to be associated with vasadilation of dependent arterioles and small blood vessels and not due to left ventricular dysfunction or generalized fluid retention. With patients whose hyper-tension is complicated by congestive heart failure, can should be taken to differentiate this peripheral ademo from the effects of increasing left ventricular dysfunctions.

instance is comprised by congestive near transfer, care should be leaven to anterentiate this peripheral adema from the effects of increasing left vertificular dysfunction.

Information for Patients: ADALAT CC is an extended release tablet and should be swallowed whole and taken on an empty stomach. It should not be administered with food. Bo not chew, divide or crush tablest.

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of enzymes such as allocations of the control of the control of the control of the relationship to nitredipine therapy is uncertain in most cases, but probable in some. These laboratory abnormalities have rarely been associated with clinical symptoms; however, cholestasis with or without joundate has been reported. A small increase (<5%) in mean alkaline phosphatase was noted in patients treated with ADALAT (C. This was an isolated finding and it rarely resulted in values with if elloustial the normal range. Rare instances of allergic hepatitis have been reported with nifedipine treatment. In controlled studies, ADALAT CC did not adversely affect serum uric acid, glucose, cholesterol or potassium.

Nifedipine, like other calcium channel blockers, decreases platelet aggregation in vitro. Limited clinical studies have demonstrated a moderate but statistically significant adverses in platelet aggregation and increase in bleeding time in some infedipine patients. This is thought to be a function of inhibition of calcium transport across the Positive direct Coombs' test with or without hemolytic onemin has been reported but a causal relationship between infedipine administration and positivity of this laboratory test, including hemolysis, could not be determined.

Although nifedipine has been used safely in patients with renal dysfunction and has been temporated.

tes), inclouding historys, count not externiment.

Although rifedigine has been used safely in patients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, rare reversible elevations in BUN and serum creatinine have been reported in patients with pre-existing chronic renal insufficiency. The relationship to infledipine therapy is uncertain in most cases but probable in some. Drug Interactions: Beta-adrenergic blocking agents: (See WARNINGS).

ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placebo-controlled clinical trial. However, there have been accasional literature reports suggesting that the combination of nitedipine and beta-ordeneracyic lookcing drugs may increase the likelihood of congestive heart failure, severe hypotensian, or exacerbation of angina in patients with cardiovascular disease. Digitalis: Since there have been isolated reports of patients with cardiovascular disease. Digitalis: Since there have been isolated reports of patients with cardiovascular disease. and there is a possible interaction between digaxin and ADALAT CC, it is recommended that digaxin levels be monitored when initiating, adjusting, and discontinuing ADALAT CC to avoid possible over- or under-digitalization.

to avoid possible over- or under-digitalization.

Coumanin Anticoagulants: There have been rare reports of increased prothrombin time in patients taking coumanin anticoagulants to whom nifedipine was administered. However, the relationship to nifedipine therapy is uncertain.

Quintiline: There have been rare reports of an interaction between quintiline and nifedipine (with a decreased plasma level of quintiline).

Cimetiline: Both the peak plasma level of quintiline.

Cimetiline: Both the peak plasma level of nifedipine and the AUC may increase in the presence of cimetiline. Rantifildine produces smaller non-significant increases. This effect of cimetiline may be mediated by its known inhabition of hepatic cytochrome P450, the enzyme system probably responsible for the first-pass metabolism of nifedipine. If nifedipine therapy is infinited in a patient currently receiving cimetiline, cautious literation is advised.

py is initiated in a patient currently receiving cimehdine, cautious litration is advised.

Carcinagenesis, Mutagenesis, Invajaurment of Fertility: Nifedipine was administered orally to rais for how years and was not shown to be carcinagenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. In vivo mutagenicity studies were negative.

Pregnancy: Pregnancy Category C. In rodents, rabbits and monkeys, nifedipine has been shown to have a variety of embryatoxic, placentotoxic and fetotoxic effects, including stunted fetuses (rats, mice and rabbits), digital anamalies (rats and rabbits), rib deformities (mice), cleft polate (mice), small placentos and underdeveloped charionic villi (monkeys), embryonic and fetal deaths (rats, mice and rabbits), profonged pregnancy (rats; not evaluated in other species), and decreased neonatal survival (rats, rot evaluated in other species). On a mg/kg or mg/m² basis, some of the doses associated with these various effects are higher than the inaximum recommended human dose and some are lower, but all ore within an order of magnitude of it.

The digital anamalism and in nifedipine-exposed rabbit page are strikingly similar to

The digital anomalies seen in infedigine-exposed rabbit puss are strikingly similar to those seen in puss exposed to phenytoin, and these are in turn similar to the pholangeal deformities that are the most common malformation seen in human children with in utaro exposure to phenytoin.

There are no adequate and well-controlled studies in pregnant women. ADALAT CC should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

be used during pregnancy only if the potential benefit justifies the potential risk to the tetus.
Mursing Mothers: Nifedigine is excreted in human milk. Therefore, a decision should
be made to discontinue nursing or to discontinue the drug, taking into account the
importance of the drug to the mother.
ADVERSE EXPERIENCES: The incidence of adverse events during treatment with
ADALAT CC in doses up to 90 mg daily were derived from multi-center placebe-controlled
clinical trials in 370 hypertensive potients. Alenold 50 mg once daily was used concomitantly in 187 of the 370 patients on ADALAT CC and in 64 of the 126 patients on placebo.
All adverse events reported during ADALAT CC therapy were tabulated independently of
their causal relationship to medication.

The most common odverse event reported with ADALAT® CC was peripheral edema. This was dose related and the frequency was 18% on ADALAT CC 30 mg daily, 22% on ADALAT CC 60 mg daily and 29% on ADALAT CC 90 mg daily versus 10% on placebo.

ADMAIN Co. oring doiny and 27% on AnALAI CV. oring anny versus 10% on praceso.

Other common adverse events reported in the above placebo-controlled trials include. Headache (19%, versus 13% placebo incidence); Flushing/heat sensation (4%, versus 0% placebo incidence); Dizziness (4%, versus 2% placebo incidence); Flushing/heat sensation (4%, versus 0% placebo incidence); Russea (2%, versus 1% placebo incidence); Constipation (1%, versus 0% placebo incidence);

Where the frequency of adverse events with ADALAT CC and placebo is similar, causal relationship cannot be established.

retunorsing cannot be estudence.

The following odverse events were reported with an incidence of 3% or less in daily doses up to 90 mg:

Bedy as a Wihole/Systemic: chest pain, leg pain Central Nervees System: paresthesia, vertigo Dermatolegic: rash Gustrointestinal: constipation Musculoskelete: leg cramps Respiratory: epistaxis, rhinitis Urogenital: impotence, urrianry frequency

Other adverse events reported with an incidence of less than 1.0% were:

Other odverse events reported with an incidence of less than 1.0% were:

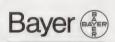
Body as a Whole/Systemic cellulitis, chills, facial edema, neck pain, pelvic pain, poin Cardiovasculars atrial fibrillation, bradycardia, cardiac arrest, extrasystole, hypotension, polaitations, phiebitis, postural hypotension, tarbycardia, cuteneous angiectases Ceatral Nerveus Systems anxiety, confusion, decreased libido, depression, hypertonia, insamnia, samnolence Dermatologic: pruritus, sweating Gustraintestinual: abdominal pain, diarrhea, dry mouth, dyspepsis, esophagalis, flatinence, gastrointestianal hemorrhage, vomiting Hematologic: lymphadenopathy Metabolic: gout, weight loss Musculoskeletal: arthrolgia, arthritis, myalgia nespiratory: dyspnea, increased cough, rales, pharyngitis Special Senses: abnormal vision, amblyopia, conjunctivitis, diplopia, himitus Urogenital/Reproductive: kidney calculus, nocturia, breast engargement

The following adverse events have been reported rarely in patients given nifedipine in other formulations: allergenic hepatitis, alapecia, anemia, arthritis with ANA (+), depression, erythromelalgia, exfoliative dermatifis, tever, gingival hyperplasia, gynecomastia, leukapenia, mood changes, muscle cramps, nervousness, paranoid syndrome, purpura, shakiness, sleep disturbances, syncope, taste perversion, thrombocytopenia, transient blindness at the peak plasma level, tramor and urticaria.

PZ500025BS 6/95 © 1995 Bayer Corporation 5387 Printed in USA

References: 1. IMS NPA+, January 1996. 2. Glasser SP, Ripa SR, Allenby KS, Schwartz LA, Commins BM, Jungerwirth S, on behalf of the Nifedipine Study Group. The Efficacy and Safety of Once-Daily Nifedipine Administered without Food: The Coat-Core Formulation Compared with the Gastrointestinal Therapeutic System Formulation in Patients with Mild-to-Moderate Hypertension. Clin Ther. 1995;17(2):296-312. 3. Glasser SP, Jain A, Allenby KS, Shannon T, Pride K, Pettis PP, Schwartz L. MacCarthy EP, and the Nifedipine Study Group. The Efficacy and Safety of Once-Daily Nifedipine: The Coat-Core Formulation Compared with the Gastrointestinal Therapeutic System Formulation in Patients with Mild-to-Moderate Diastolic Hypertension. Clin Ther. 1995;17(1):12-29.

4. Adalat® CC Product Monograph, April 1995 5. Redbook Update. Montvale, NJ, Medical Economics Data, Inc., June 1996.



Pharmaceutical Division

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Glossary of Financial Terms

This glossary of financial terms provides brief definitions of common financial terms presented in the forthcoming MSMS report. For many of these terms there are complex issues of measurement, making comparisons among hospitals difficult. For more detailed definitions of these and other financial terms, refer to any standard accounting textbook. For specific information on how your hospital computes any of these measures, contact your hospital's financial staff.

Hospital financial statements generally consist of two major reports: a Balance sheet and an Income Statement. Below is an example of a typical hospital Balance Sheet, highlighting some important elements. More detailed descriptions are presented in the Glossary Financial statements usually give two years of data **Hospital XYZ** Assets are the dollar value of **Balance Sheets** a hospital's holdings (dollars in thousands) 12-31-1995 12-31-1994 Fiscal year ending [1] Cash and securities 61,315 60.243 Accounts receivable 35,156 Accounts receivable 37,476 are the amounts owed Less: uncollectable A/R [2] (7,934)(8,673)3,825 7,154 Other current asset to the hospital by Total current assets 94,682 93,880 patients and payers 90,264 89,658 Long-term assets Less: accumulated depreciation (21.187)(17.683)Total Assets 258,441 259,735 Liabilities are the amounts owed by the Liabilities and Fund Balan hospital to vendors, 42,479 43,685 Total current liabilities banks and bond holders Total Long-term liabilities 30.916 31,906 Total Liabilities 73,395 75,591 General fund balance 174,046 173,144 Fund balances indicate Total Fund Balances [3] 185,046 184,144 the amount of assets that Total Liabilities and Fund Balance 258.441 259,735 the hospital owns (most of which is comprised of the hospital's long-term Note that Total Assets equals Total Liabilities assets of property, plant and Funds (this is where the name balance and equipment) comes from) - The financing behind assets are either borrowed or owned Notes to Balance Sheets: [1] Fiscal year ends vary among hospitals - common dates are 12/31 and 6/30 [2] Uncollectable accounts receivable can include uncollectable notes receivable, and represents an estimate the amount that is not likely be paid. [3] Total Fund Balances include the general fund plus any amounts in endowments, specific purpose funds and plant replacement funds.

ACCOUNTS RECEIVABLE - The amount of money owed to the hospital by patients and payers for services provided. Accounts receivable (frequently abbreviated A/R) are the amounts normally expected to be paid. UNCOLLECTABLE RECEIVABLES subtract bad debts and other items to arrive at an estimate of the amount that is likely to be collected.

ACUTE BEDS IN SERVICE - A count of the number of hospital beds available for general, short-stay, acute care patients. Beds in service is defined as beds that are licensed, staffed, and ready for patient care. Beds in service is a good measure of the relative size of a facility, but it is not the only measure, given the growing importance of capacity for ambulatory care services and long-term care services.

ASSETS - The total dollar value of physical and financial holdings of the hospital, measured by purchase price. CURRENT ASSETS are assets that can usually be exchanged for cash within one year. Examples of current assets include cash, stocks, bonds and other securities, accounts receivables, notes receivables and prepaid expenses. LONG-TERM ASSETS are assets that are expected to be maintained for more than one year. Examples of long-term assets are property, plant and equipment.

AVERAGE AGE OF ASSETS - An indicator of the age of the physical structure of a hospital, measured by the ratio of accumulated depreciation to the annual amount of depreciation expense. If a hospital fully depreciates evenly over a period of 10 years (i.e., its assets are used up in 10 years), then the recording of 1/10 of its value as depreciation each year would yield a good measure of average age. The reality is that assets are continuously added to, improved and renovated, making average age less precise. Still, having an average age of assets of twelve or more generally reflects an aging facility in need of renovation.

BED DAYS AVAILABLE - A count of the number of acute beds in service that were available for patient care during the year. Since hospitals may vary the staffing of beds during the year, bed days available may be different from simply (Beds * 365 Days).

CASH AND SECURITIES - The amount of money held at the hospital and in banks, in the form of cash, checking and savings accounts and marketable securities, such as stocks and bonds.

DAYS CASH ON HAND - An indicator of a hospital's ability to pay its bills, measured by the ratio of cash and securities to average expenses per day. Generally, hospitals seek to maintain 60 or more days of cash on hand for payment of current liabilities.

DAYS IN RECEIVABLE - An indicator of how quickly receivables are being collected, measured by the ratio of accounts and notes receivable to patient revenue per day. Since more receivables are in the form of accounts receivable, this number generally indicates how quickly hospital bills are being collected from patients and payers. Favorable values are generally lower than the median for an area.

DEPRECIATION EXPENSE - The amount of the original purchase price of a long-term asset counted as an expense during a year. Frequently, hospitals use "straight-line depreciation", meaning that if an asset has a useful life of 10 years, annual depreciation expense will be 1/10 of purchase price per year. ACCUMULATED DEPRECIATION is the sum of depreciation expenses up to that point in time for all long-term assets currently in use.

EQUITY FINANCING RATIO - An indicator of hospital financial structure, measured by the ratio of fund balances to assets. This ratio indicates how much (in percentage terms) the hospital owns of its assets. The inverse of this ratio, the DEBT RATIO, indicates how much (in percentage terms) the hospitals borrows to hold its assets. Favorable equity financing ratios are generally higher than the median for an area.

FUND BALANCE - The amount of assets minus liabilities the hospital owns; not available as cash. Fund balance is usually referred to as stockholder's equity or ownership in for-profit organizations. It bears repeating that fund balance is not the balance in some cash or checking account. The ownership stake of a hospital is in all its assets, which include property, plant and

equipment. The principal fund balance is termed the "general fund". Hospitals may have "specific purpose" funds for endowments, plant replacement and expansion and other purposes.

INCOME STATEMENT - A common financial statement that provides detailed information on the revenues and expenses of an organization for the calculation of net income.

LIABILITIES - Amounts owed to another entity (such as an individual or company). CURRENT LIABILITIES are the amounts the hospital owes that are usually paid within one year. Examples of current liabilities are wages and salaries payable and short-term bank loans. LONGTERM LIABILITIES (often referred to as long-term debt) are the amounts the hospital owes that are usually paid over several years. Examples of long-term liabilities include hospital mortgages and bonds.

NET INCOME - The net amount of total revenues minus total expenses. Net income is the "bottom" line for an income statement. OPPERATING NET INCOME is the difference between operating revenues and operating expenses. NON-OPERATING NET INCOME is the difference between non-operating revenues and non-operating expenses, usually summarized in one line. Non-operating activities include medical education, cafeteria, gift shop, laundry services, medical office buildings, etc.

OPERATING EXPENSE - The amounts spent in the process of providing patient care services. Hospitals provide varying levels of detail in the sources of operating expenses, but will usually separate at least general expenses and depreciation expenses.

OPERATING EXPENSE PER ADMIS-SION - An indicator of patient severity and efficiency, measured by the ratio of operating expenses to admissions. Favorable values of operating expenses per admission are generally lower than the median for an area.

OPERATING INCOME PER ADMIS-SION - An indicator of profitability, measured as revenue per admission minus operating expense per admission. This indicator can be measured more precisely if both revenues and expenses are determined separately for inpatient services. However, it can be difficult to separate expenses for inpatient and outpatient cases.

OPERATING MARGIN - An indicator of hospital profitability, measured as the ratio of op-

erating income per admission to revenue per admission. Favorable values are generally higher than the median for an area.

OPERATING REVENUES - The amount earned from providing services to patients, measured by charges. GROSS PATIENT REVENUES are the sum inpatient and outpatient services. ALLOWANCES are the amounts of revenues not expected to be paid due to discounts and contract requirements of Medicare, Medicaid and many insurers and health maintenance organizations. TOTAL OPERATING REVENUES is also termed net operating revenues and is measured as gross patient revenues minus allowances.

REIMBURSEMENT TO CHARGE RATIO - An indicator of the level of discounting that occurs in a market, measured as the ratio of total operating revenues to gross patient revenues. Given all of the special types of contracts that exist in the market, this ratio has become a

less meaningful indicator over time, but is still commonly presented by hospitals.

RETURN ON ASSETS - An indicator of hospital profitability, measured as the ratio of net income to assets. Favorable values are generally higher than the median for an area.

REVENUE PER ADMISSION - The average amount the hospital receives, net of discounts and adjustments, per admission.

The Michigan Psychoanalytic Society's Twenty-Second Annual Symposium

"Transitions in Womanhood: Menarche, Marriage, Motherhood and Menopause"

Saturday, October 5, 1996

The Ritz Carlton 300 Town Center Drive Dearborn, Michigan

9:00 a.m. to 4:30 p.m.*

"From Girl to Woman," Malkah Notman, M.D. (Brookline, MA)

"Mother/Mate: A Woman's Dilemma," Phyllis Tyson, Ph.D. (La Jolla, CA)

"From Pregnancy to Motherhood: A Psychoanalytic View," Dinora Pines, M.D. (London, UK)

"Psychoanalytic Perspectives on Menopause and Aging in Women," Ruth Lax, Ph.D. (New York, NY)

Deanna Holtzman, Ph.D. (Birmingham, MI) Moderator

For further information, please call the Michigan Psychoanalytic Society, (810) 851-3380

*6 hours of C.M.E. Credits

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Charting a course for a successful year

Excerpts from president's installation speech

By Janet Gregory

Pennis Connor, the skipper of several America's Cup Challenges states, "There's a special force that gets people working as a team. Once that force is in action, the team is virtually unbeatable." We, physician spouses and physicians, the Michigan State Medical Society Alliance and the Michigan State Medical Society are a team. Together we can make a significant impact on our community and the health and well being of its citizens. We can make a difference.

The Michigan State Medical Society Alliance mission is to work in partnership with Michigan State Medical Society; to develop, implement, and support educational programs that improve the public health; to educate about legislative issues that impact the practice of medicine; to provide support for the medical family; and to serve as a resource for county alliances. As your captain, I am going to steer you towards one to two "doable" projects in our areas of special concern.

HEALTH CARE: Our primary focus will be to work in partnership with MSMS to correct the immunization rate in our state.

We will continue to support the American Medical Association Alliance program, "PROJECT SAVE". This year Governor Engler will proclaim October 9, 1996 as "SAVE (Stop America's Violence Everywhere) DAY." We will join with MSMS in working with the media, emergency rooms, and doctor's offices to display the "1-800-NO-ABUSE" phone number.

LEGISLATIVE: Our former Alliance phone bank will now become "FAX ALERT." In this age of technology we can now, in minutes, put directly into your hands important legislative developments that need your immediate action!

This is, as we all know, an election year. I am asking you to join us in support of the efforts of the Alliance for Judicial Accountability. We have

made past strides in tort reform, but it could all end with a challenge in the supreme court. We need to be educated as to which candidates understand the concerns of medicine, and in turn, talk with our friends.

We need to have the ears of our legislators in office. They must know our names and our faces, so we can be sure that they will listen when we share our concerns about medicine and the

care of patients. I hope that all counties in conjunction with their medical societies will form an advisory committee to meet periodically with their legislators to keep informed on medical issues. Let them know how strongly we feel about the "Patient Bill of Rights." Join MDPAC and help us to create a strong voice for medicine.

MEMBERSHIP: We need to reach out to our young physician spouses while they are in training and share our expertise, guidance, and support. I am asking all counties with training programs at their hospitals to contact them as Oakland County did to sponsor their residents and students. If we can convince them of our great value to their lives and future while in training, we'll have them as lifelong crew members.

"Happiness" is defined as having fulfilling work and relationships. We need to be involved in activities that challenge our skills and have a clear purpose.

Again, Dennis Connor states, "Happiness lies in the job of achievement and the thrill of the creative effort." Put more simply, it is in the "doing" that we find our rewards. Success is a journey, not a destination.

Janet Gregory is the current president of the Michigan State Medical Society Alliance.



Come to the Annual Scientific Meeting!

Michigan infectious disease expert H. Gunner Deery, MD, will deliver a plenary session on bacterial-resistant antibiotics.

By Jean Capriotti

hat happens when certain drugs no longer achieve the end result for which they are intended? What happens when antibiotics no longer do the trick in killing bacteria? Perhaps the most important question is how is it that in Michigan certain bacterial illnesses are resistant to these antibiotics?

At the 1996 MSMS Annual Scientific Meeting in November, H. Gunner Deery, MD, Petoskey, will address these questions and more.



Doctor Deery

Doctor Deery is the president of the Michigan Infectious Disease Society, and will be giving a plenary session at the Annual Scientific Meeting on the use and misuse of bacterial- resistant antibiotics.

According to Doctor Deery, Michigan is currently experiencing what Europe, Africa, and other parts of the United States have already endured in the realm of antibiotics. His main goal for the Annual Scientific Meeting is to educate others so that the problem can be minimized.

"I am going to literally go through the entire family of antibiotics and give my opinion for developing appropriate in patient hospital use, and also proper outpatient use," he said. Streptococcus pneumoniae is one of the bacteria that no longer respond to penicillin. Physicians and other scientists have noticed this phenomenon especially over the past two-three years. This tipped off the infectious disease community that there was a problem with resistance to antibiotics. As a corollary to the issue of antibiotic resistance, enterococcus has also been found to be resistant to vancomycin.

Doctor Deery stated that with the enterococcus antibiotic resistance, there is no good therapy to treat this bacteria. The Infectious Disease Society is working in conjunction with the Michigan Department of Community Health to educate not only physicians but also the public on the use and misuse of antibiotics.

"With these bacteria we are now experiencing what happened before the invention of antibiotics," Doctor Deery said.

The plenary session by Doctor Deery is just one of the components of the 1996 MSMS Annual Scientific Meeting. The meeting runs November 14-15-16 at the Lansing Center in downtown Lansing. For complete course information contact Sarah Cressman at MSMS headquarters, 517-336-5727 or e-mail her at scressman@msms.org.

Legislative Breakfast

Join MSMS for breakfast on November 14, 1996, 7:00-8:15 a.m. as we recognize legislators and leadership in the medical community. James K. Haveman, Jr., Director, Michigan Department of Community Health, as well as champion of tort reform Rep. Joe Porreca (D-Trenton), and others have been invited to address an intimate gathering just prior to the MSMS Annual Scientific Meeting. For further information regarding this event, please contact Donna W. LaGosh, Chief, Political Affairs or Bryce W. A. Docherty, Assistant, Legislative Affairs at 517-336-5741.

MSMS Annual Scientific Meeting returns to Lansing November 14-16

These MSMS members attended the Annual Scientific Meeting for the first time in 1995:

"Probably one of the big things that spurred me to go was the location. It was nice that there were a variety of things to choose from."

> -Nathan Chase, MD Clarkston

"I thought the meetings were great. It was held in a good location, especially coming from the west side of the state. The speakers were good and current. I first learned of Michigan's low immunizations rates at the meeting. Now that I'm not in practice my interest is more varied; this meeting covered a variety of subjects."

> -John M. DeVries, MD Holland, retired

"The meeting was very well done, and well organized. I was very satisfied with the program in general. Speaking as a practicing internist, the topics were well chosen for clinical relevance. I liked that the speakers and panels were oriented towards practicing physicians."

> —John English, MD Marquette

"The location was convenient and because it was in the middle of the state it allowed for contact with



Lansing Center again will host MSMS Annual Scientific Meeting. Dates are November 14-16, 1996.

physicians from all over the state. I was most impressed with the women's health issues presented by the OBGYN's and the psychiatrists. Great way to get CMEs."

> -Pamela D. Johnson, MD Rochester Hills

"Location was great. Impressed with the information because it was so current. Especially impressed with the hormone replacement speaker and the new treatment regiments."

> -Glynda Moorer, MD East Lansing

"I attended the session on computerizing medical records which was particularly interesting to me because I was just starting a practice. It was helpful to listen to the experts good and bad points in regards to this. Nice facilities and set-up."

> -Mark A. Walker, MD Marshall

"I enjoyed the whole thing - really liked the lectures. I attended the meeting because it featured a lot of occupational medicine. Location was convenient."

> -Gilbert I. Sales, MD Grand Rapids

Jean Capriotti is an MSMS staff writer.

Michigan Children's Immunization Registry:

An Important Tool In Reaching & Maintaining 100% Rates Among Two-Year-Olds

By James K. Haveman, Jr., MSW



We are committed to a system that will be accessible by all practices, computerized or not.

he support of the Michigan State Medical Society is appreciated as we implement the Michigan Children's Immunization Registry. I look forward to collaborating on the registry and other initiatives to quickly raise Michigan's immunization rate for two-year-olds from 64%, the lowest in the nation, to 100%. This is a responsibility that we all bear, in both the public and private sectors. To say that our national status is a professional embarrassment is to understate the seriousness of this circumstance. We must fulfill our obligation to fully immunize all children by age two.

Briefly, the Michigan Children's Immunization Registry will be a network of regional systems that will cover the entire state. Each system will maintain a database of information that will provide physicians with a child's immunization history and enable tracking and recall. The databases will be populated with birth records from the State Registrar's office. You will be able to retrieve your patient's records for assessment purposes and enter information about vaccines administered to update the record.

Advantages are many. You will have immediate access to accurate assessment data without maintaining an elaborate filing system in your office. The registry's tracking and recall functions will give you the means to flag patients who are due for a vaccination and notify them that they need to schedule an appointment.

Prompted by the recall notice, patients will be reminded each time an immunization is due. This will assist parents in getting appointments scheduled on time for each vaccination date. The ultimate advantage, of course, is protection and disease prevention for their children.

This will also help avoid the missed opportunities. If physicians and parents are both aware that a particular immunization is due, there can be no doubt that parents must make an appointment and providers must deliver the vaccination.

It is difficult for those outside the health care disciplines to understand why our rate is so low when they learn that a typical child has seen a physician at least ten times by the time they are two, and only five visits are needed to complete the recommended vaccinations. In all candor, it's difficult for me to comprehend. I believe the Michigan Children's Immunization Registry will enable better vigilance and result in fewer missed opportunities.

At a systems level, advantages of the network approach include the ability of regional user coalitions to implement the architecture in ways that best accommodate unique regional needs. The network will also interface with your existing hardware and software. If you don't have computers in your practice and have no plans to add them, the system will provide an interface through touchtone telephone. Using the touch-tone keypad, you would be able to access the records you seek, which could be reported to you by interactive voice response or sent to your fax machine. We are committed to a system that will be accessible by all practices, computerized or not.

The involvement of the Michigan State Medical Society in Michigan's immunization initiatives has been a valuable contribution in getting Michigan moving to improve rates among two-year-olds. Your participation in the immunization registry provider survey and work group meetings has been equally important. I look forward to continued collaboration in implementing the Michigan Children's Immunization Registry and protecting young children from the risks of these diseases in the particularly vulnerable years of early childhood.

Mr. Haveman is director of the Michigan Department of Community Health.

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MSMS members meet legislators at 1996 MSMS Capitol Check-Up



Passers-by and the band of the day (Kennedy High School Symphonic Band, Taylor) added color under the banner for the 1996 MSMS Capitol Check-Up. The event was sponsored by MSMS, the MSMS Alliance and the Michigan Medical Group Managers Association.



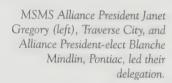
The day began with a presentation on grassroots political activism by Mike Dunn of the AMA Washington office. Legislative updates followed. In the afternoon, MSMS members met with legislators on crucial bills regarding scope of practice, managed care and Medicare/Medicaid reform.



A gala white tent on the Capitol lawn housed 250 physicians, MSMS Alliance members and group managers who met over lunch with their legislators.



Kalamazoo and Ingham county delegations lunched with Rep. Laura Baird (D-Okemos) left. Next to Reb. Baird are Brian McCardle. MD, Lansing, and Kalamazoo Academy of Medicine Executive Director Susan Saewert.





Planning their strategies for visiting their legislators' offices in the afternoon were, from left facing camera, Charles R. Schmitter, MD, Ann Arbor; Robert J. Dean, DO, Grand Rapids; James D. Grant, MD, Bloomfield Hills; and Kevin Tremper, MD, Ann Arbor. Backs to camera are Tom George, MD, Kalamazoo, left, and N. Sean V. Ohanian, MD, Bloomfield Hills.

New Medicare Rules

New rules mean added demands for teaching physicians

By Karen Bouffard

n July 26, 1995, federal policymakers proposed plans to alter the rules for payment of teaching physicians under Medicare Part B when a resident or clinical fellow is involved in a patient's care. Noting broad inconsistencies in the application of its previous policies, HCFA proposed a new rule to completely replace its former criteria.

The new policy represented a departure from the "attending physician" criteria established in April 1969 with Intermediary Letter 372. Reiterated and clarified through subsequent legislation and policymaking, the main requirement of IL-372 was that a single attending physician, identified by providing "personal and identifiable direction" to the interns and residents who provided the actual services to the patient, would be qualified for Part B Payment.

In a decision that drew thousands of letters from medical schools, residency programs and other entities that bill for physicians' services in teaching hospitals and GME programs, policymakers announced their belief that "the most important consideration should be the presence of the teaching physician during the key portion of the service or procedure being furnished by the resident, and that requiring both an attending physician relationship and the presence of that same physician during every billable service is no longer warranted."

With few revisions, most notably an exception for outpatient services in family practice centers and an extension of the deadline for compliance to July 1, 1996, the proposed rule was finalized in the Federal Register in December 1995.

While George Gerber, MD, Medicare Medical Director in Michigan for Healthcare Service Corporation, the administrator for Medicare in the State of Michigan says, "I don't think there's a great deal of change," for some institutions the new demands for increased documentation will require major operational adjustments.

"(The change) simplifies the rule and makes it more direct than Intermediary Letter 372. Those who were following the rules previously will have very little trouble complying now. They will have to document more clearly, that's all," Doctor Gerber says. "Saying physicians must more carefully document

may add some charting time - - but if you want to get paid for a service you have to provide a service," Doctor Gerber adds, noting that the revision was preceded by a 1995 government audit of the Clinical Practices of the University of Pennsylvania, the physician faculty practice component of the University of Pennsylvania Health System. The audit resulted in a \$30 million settlement to resolve complex billing issues surrounding Medicare Part B professional fee payments. "A lot of physicians may not have done that, but the requirement has always been there.

"Simply countersigning a resident's note is not going to be enough."

According to John E. Billi, MD, who as associate dean for clinical affairs at the University of Michigan Medical Center is responsible for third party reimbursement networking, in the past there has been confusion about interpretation and a need for clarification of the rules.

"Medicare has always required close involvement of attending physicians. Intermediary Letter 372 stipulated requirements such as that the attending physician provide 'personal and recognizable' services to the patient — but the documentation was not explicit."

Doctor Billi says that U of M Medical Center, which includes numerous satellite clinics, will require additional hours spent by billing personnel to ensure adequate documentation when a resident is involved. The changes will be substantive—not merely cosmetic.

For some
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adjustments.

Elements of the U of M Health Center's plan for compliance include setting up an ad hoc Task Force: developing institutional standards; an orientation plan for faculty physicians, house staff and billing personnel; the move to a centralized billing office; a monitoring program; carrier liaison to seek input on compliance from the Michigan Medicare carrier; and a work redesign plan that will include dramatic changes in the house officer workforce, replacement options such as a 24-hour House physicians and acute care nurse practitioners, and new procedures to deal with various aspects of the new rules such as restrictions on payments of surgeons and anesthesiologists for concurrent surgeries.

"For us at the University we at least have a mechanism to get this accomplished. Besides Henry Ford Health Center we're the only one (in Michigan) with a fully integrated group practice. The government is looking for the institution to provide compliance, but for a community hospital that has a residency training program billing is done by private practitioners," Doctor Billi says, "It's unclear as to how (the need

for additional documentation) is to be carried out and monitored. That's the challenge."

Doctor Billi says he is concerned that the new rules may prove unnecessarily burdensome.

"We've always made every effort to do an aggressive job of documentation. We've taken many steps to ensure that care is appropriate. My concern is that the level of documentation that's being requested is more than what's necessary to meet good medical care."

A similar view is held by John MacKeigan, MD, a colon-rectal surgeon with Blodgett Memorial Medical Center's Ferguson Clinic.

"From the western Michigan perspective there will be little implication in that the responsibility of academic staff to be present for all procedures is standard for all the programs I'm involved with," he says. "There have been situations where teaching physicians take full responsibility and liability but cannot get paid - - under both the old rules and new rules—but that's just part of our responsibility to our patients and to our teaching programs.

"Like any set of rules there are some good

"It's unclear as to how (the documentation) is to be carried out and monitored. That's the challenge." -Doctor Billi

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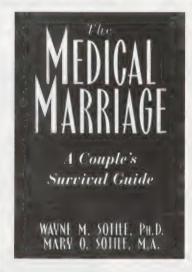
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"There is a need for a flexible system, for the ability to dialog with HCFA." -Doctor Minnick aspects, such as that it puts responsibility on the teaching staff to document. But at the same time. (the new rules may) make some good teachers and programs comply with rules that will be burdensome.

"My concern is that the rules may just be putting more demands on teaching staff at a time when they are already stretched by decreasing reimbursement in their own practices and by managed care, so that their time to devote to teaching may be increasingly limited."

Steven E. Minnick, MD, is Director of Medical Education for St. John Hospital and Medical Center in Detroit. He believes the requirement for clear documentation of the physician's physical presence will help in the education of residents.

"It will strengthen the need for definitive supervision. There has been a need for clarification because previously the rules were interpreted in too many different ways."

Doctor Minnick says he believes there should be a mechanism to modify the rules to fit the needs of various specialties, for example, psychiatry. "For an individual in the last year of training, in terms of the nuances of the specialty, to require the physical presence of the teaching physician, is that appropriate? Or, does an attending really have to be there suture by suture to check a laceration?

"In terms of the impact of the rules, I think it's good that we get clarification. But there is a need for a flexible system, for the ability to have dialog with HCFA.

"I hope there's not a philosophy that these can't be further defined."

Thomas J. Zuber, MD, who practices with Midland Family Physicians, PC, and is also an assistant clinical professor at MSU, worked with HCFA for about eight months ending in October 1995, urging policymakers to recognize and accommodate the needs of family practice physicians. Working with the American Academy of Family Practice Physicians, Dr. Zuber was instrumental in bringing about the "Outpatient Exception" which applies to services provided in an outpatient setting by residents in family practice, general internal medicine, geriatrics,

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general pediatrics and obstetric/gynecology.

Medicare carriers may make payment for low to mid-level Evaluation and Management services when furnished by a resident without the attending's presence at certain outpatient departments of hospitals or other ambulatory care centers. The resident must have completed six months of training, and the exception applies to low and mid-level E & M services only. The teaching physician may supervise no more than four residents at a time; must have no concurrent responsibilities; must be immediately available; must review each case and each visit; and must document their involvement. The services must be for an identified group of continuity patients, and can include acute care for undifferentiated problems or chronic care for ongoing conditions; coordination of care; or comprehensive care not limited by organ system or diagnosis.

"There was a special carve-out created for family practice and primary care physicians that are trained to perform outpatient medicine. They spend so much time in training, (the rule change) would have put tremendous strains on teaching physicians," Doctor Zuber says.

"HCFA was actually very willing to listen, and accepting of our proposals. We got most of what we asked for.

Doctor Zuber adds that many specialty groups chose not to participate in the hearings process. For several specialties the new rules may represent some hardships. While he supports additional softening of the rules in some cases, overall he believes the new rules are acceptable.

"I don't think the rules are so bad," he says. "HCFA has needed to establish some consistent application of the rules."

According to Doctor Gerber, guidelines for implementation released in late June represent only initial instructions, so additional changes may occur. "The only way to enforce compliance is through post-payment audit," he adds, noting that he doesn't yet know what procedures will be used in determining audits. According to Doctor Gerber, penalties would most likely include recovery of improperly paid services.

The author is a Williamston, Michigan-based freelance writer.

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Highlights

New 1996 Medicare Payment Guidelines for Teaching and Attending Physicians

By Thomas J. Zuber, MD

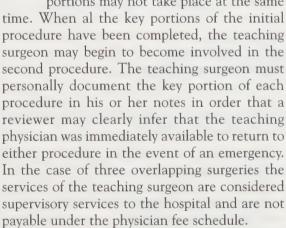
uidelines for implementation of the new medicare payment rules were released in late June. Following are some highlights. For more information, or to obtain a copy of the completed guidelines, please call Joyce Nurenberg at MSMS at 517-336-5722.

Hospital Services

1. A teaching (attending) physician must be present for a key portion of the time during the performance of the service for which payment is sought.

2. The attending must be present during all critical portions of a surgery or procedure and be immediately available to furnish services during the entire service or procedure. The operative note must indicate when the attending's presence began and ended. Endoscopy requires the attending's presence throughout the viewing.

3. Overlapping surgeries: In the case of two surgeries the teaching surgeon must be present for the key portions of both operations. Therefore, the key portions may not take place at the same



4. Anesthesia: The full fee will be paid if a teaching anesthesiologist is involved in a

procedure with one resident. The teaching physician must be present during induction, emergence, and any other portion of the procedure payable on a time basis. If an anesthesiologist is involved in concurrent procedures with more than one resident or with

a resident and non-physician anesthetist the anesthesiologist's services will be paid for as medical direction. The teaching physicians's presence is not required during the preoperative or post-operative visits.

5. For minor procedures that take only a few minutes, for example, simple sutures, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill.

6. The payment level for hospital visits must reflect the extent and complexity of the service provided by the attending. The attending must be present for the key portion of the visit.

7. The attending's presence during the service or procedure must be documented in the medical record. Time spent talking to residents at the nurses station does not count as services furnished to a patient; this would not be considered a reimbursable service if this was the only service provided by the attending physician.



Doctor Zuber

Moonlighting Services of Residents

- 1. The services must be identifiable physician services.
 - 2. The resident must be fully licensed.
- 3. The services are separate from those required as part of an approved GME program.

Outpatient Office Exception

The types of residency programs most likely to quality for the primary care exception include:

Family Practice, General Internal Medicine, Geriatric Medicine, Pediatrics and Obstetrics/ Gynecology. Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. For example, where antibiotics are being prescribed as well as psychotropic drugs.

1. Medicare carriers may make payment for low to mid-level Evaluation and Management services when furnished by a resident without the attending's presence if:

a. Services are provided at the FP Center

b. The resident has completed 6 months of internship.

c. The attending or teaching physician is not supervising more than 4 residents at a given time, and doesn't have other responsibilities at the

d. The attending or teaching physician assumes management responsibility and ensures the services provided are appropriate.

e. The attending reviews "the case" and the medical record with the resident immediately after the visit.

f. The patient is an established FPC patient.

g. The services billed are coded as 99211, 99212, or 99213 for established patients or 99201, 99202, or 99203 for new patients.

2. The attending physician must be present and examine the patient if higher level codes (99214, 99215, 99204, 99205) are reported.

3. Services provided by medical students are noncovered services, even if the attending is present in the room.

Residents in Private Offices

1. The same rules that apply to hospital visits also apply when residents see patients in a private office setting.

2. Medicare will only reimburse attending physician services in the private office setting. Consigning the resident note is not sufficient involvement to warrant payment for the service.



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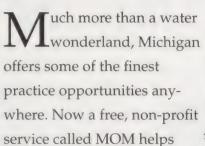
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ACROSS THE STATE

Detroit

Wayne State University and the Karmanos Cancer Institute in Detroit have discovered, altered and refined a model which will enable researchers to pinpoint exact foods, drugs, activities and chemicals having a positive or negative impact on breast cancer, according to an article in Wayne State University's New Science magazine. Prior to the development of MCF10AneoT, a human cell line derived from a single person, researchers found it too difficult to compare laboratory animals and humans because of differences in lifestyles, diet and genetic background. Fred Miller, MD, a WSU pathology professor and Karmanos Cancer Institute researcher, is responsible for taking the cell line a step further. This cell line tool is the only one available in the world and will help researchers eliminate reports that conflict with one another over what causes and prevents breast cancer.

The Greater Detroit Area Health Council has been granted nearly \$800,000 from the W.K. Kellogg Foundation to assist in the Urban Health initiative. The grant will be distributed over three years. The primary goal of this initiative is to

utilize a neighborhood approach to achieve a stronger delivery of community based primary health care services.

Ann Arbor

According to a recent study conducted by the University of Michigan, the common theory that carpal tunnel syndrome and a person's vitamin B6 status were related, has been discredited. Doctor Alfred Franzblau of the University of Michigan School of Public Health, and lead author of the study, found no correlation between a patient's vitamin deficiency, symptoms of carpal tunnel syndrome or impaired nerve function. Doctor Franzblau also states that high doses of vitamin B6 can actually cause sensory nerve damage and are neurotoxic.

University of Michigan Heart Care Program physicians Emile Daoud, MD, and Raul Weiss, MD, implanted an experimental atrial defibrillator device to correct irregular or failed beating in the heart's upper chambers. The procedure was the first use of this new technology in the state of Michigan. The Metrix Automatic Atrial Defibrillation System was developed by InControl Inc. and is under clinical trial by three participants, including U-M Health System. "Our hope is that the atrial defibrillator will allow patients to feel stronger and more confident, with reduced dependence on medication and fewer visits to the hospital or doctors office," said Adam Strickberger, MD, principal investigator in the U-M trials of the device.

East Lansing

The Michigan Physicians Mutual Liability Company has received an upgrade from B+ to B++ by A.M.Best insurance rating agency. The upgrade is an indication of very good financial performance. The rating is also a reflection of the company's strong profitability and financial potency, in addition to MPMLC's recent purchase of Kentucky Medical Insurance Company.

What is happening in your neck of the woods?

Michigan Medicine would like to develop and expand this monthly feature to include news from various sources across the state. That includes county medical societies, specialty medical societies, physician organizations, business coalitions and other organized groups involving physicians. Send your news by mail, fax, e-mail or phone to Tom Seely, chief of physician outreach programs, P.O. Box 950, East Lansing, MI 48826-0950; fax (517) 337-3490; e-mail tseely@msms. org; or phone (517) 336-5770. Photos in either black and white or color are accepted and will be run on a space available basis.

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—Willard S. Stawski, MD Grand Rapids

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Leading Michigan Physicians in an Era of Change

By Karen Bouffard

t age 56, W. Peter McCabe, MD, the 131st president of MSMS, is a member of what he describes as the "Jerry Garcia Generation - somewhere between rock `n roll and Snoot Doggy Dog." Having experienced the tail end of medicine's "salad vears," endured Vietnam and survived the malbractice crises of the 70s and 80s, Doctor McCabe's age group is just now coming into leadership in organized medicine.

Doctor McCabe views his as a 'bridge generation', uniquely qualified to lead medicine through the transition to managed care, to grapple with tough ethical issues like assisted suicide, and to search for a solution to the problem of violence.

"The spin is that doctors are part of the establishment; but I don't think we are," he says.

> "Nobody touches the face of humanity like we do. Doctors are an idealistic group - that's why we'll survive this transition to managed care. Whatever changes have occurred, the essential for us is still the same - - our primary concern is the patient."

The son of a Harvard lawver and a school teacher/homemaker, Doctor McCabe was born and raised in Providence Rhode Island, He decided

to emulate his godfather, who practiced medicine to age 84 and today, at 90, still reads pediatric journals. Doctor McCabe admires that pediatrician's calm and reassuring manner, he says, "and I always wanted to be like that."

After graduating with honors from Harvard in 1961, Doctor McCabe attended medical school at Cornell University in

New York City. It was there that he met his wife. Maureen, to whom he has been married 31 years. The McCabes have three children: Christopher, a graduate of Northwestern Law School who is beginning practice at a Denver law firm: Michelle, a Harvard graduate and aspiring film writer pursuing a career in New York City; and 13-year-old Brian, an eighth-grader at University Liggett School in Grosse Pointe. His oldest son. Christopher, was just three and a half weeks old when, after serving two years of a surgical residency program at Boston City Hospital, Doctor McCabe was drafted.

"The war showed us the foolishness of governments, to cause such carnage among young men. And for what purpose?"

Doctor McCabe spent one year alternating between a MASH hospital in Quang Tri, and the 3rd Field Hospital in Saigon. There, he reported to the Chief of Surgery, who was the army's only plastic surgeon in Vietnam. Young Doctor McCabe, 26 at the time, scrubbed with the man, and volunteered to accompany him on visits to villages and orphanages to find children in need of plastic surgery.

"We had a program to win the hearts and minds of the people by fixing cleft palates, and treating children who were burned or had other war injuries," Doctor McCabe says. "I enjoyed the molding of tissue, the pleasure of rebuilding, the fascination of form and shape." He decided to become a plastic surgeon.

Young Doctor McCabe at Camp Evans. Viet Nam, 1969.



Doctor McCabe completed the balance of his general and plastic Today, Doctor McCabe is part of a two-man independent private practice in Wayne County, and is

> The McCabe family at Doctor McCabe's installation as 1996-97 MSMS president, April 27, Dearborn.

surgery training at Henry Ford Hospital and the University of Michigan. He then went to London for a nine-month fellowship in head and neck cancer reconstruction at St. George's Hospital.

chief of plastic surgery at Detroit's St.

John Hospital. He is an expert on immediate breast reconstruction during mastectomy, of which he was an early advocate. He is also clinical assistant professor of surgery at Wayne State University and chairman of the Board of PICOM Insurance Company.

Noting his indifference to computers and enjoyment of reading the paper he quips, "unless the news is delivered on a pony it's not worth knowing." He is a self-described "lousy golfer" and "not too shabby sailor," who, he says, holds a "sick and dysfunctional loyalty" for the Boston Red Sox.

His joviality belies a deep concern about humanity, which he perceives as a conglomerate of unique individuals, the sum of its many parts. He approaches social problems in much the same way as he would approach treatment of a sick patient, bringing to bear on the ills of the world all the tools of the physician.

Doctor McCabe has chosen violence as a predominant concern of his MSMS presidency. He believes that at its roots lies moral decay, an abandonment of traditional values and individual responsibility. In his inaugural address he urged physicians to attack violence "as an epidemic, as a public health issue, and bring principles of epidemiology to bear on this cancer which is eating away at the fabric of our society."

Doctor McCabe is equally concerned about ethical issues raised by Jack Kevorkian's crusade for assisted suicide, an issue which he says "goes

to the very core of what the profession is and how it's conducted itself.

"As eccentric as I believe Kevorkian has been. he's forced us to ask questions of ourselves about compassionate care of the dying, and end of life decision-making," he adds. "Physicians are trained to act. We pull out all the stops for our patients. When the public supports assisted suicide, are they saying, 'I don't want to suffer when I die? Why do you feel you have to intervene in everything?""

"Maybe in some situations we need to think about that. But that's a long way from actively assisting suicide. It's a thorny, thorny issue, and one we have to deal with."

Doctor McCabe has been a leader among physicians since the mid-1970s, when he helped form, and later chaired, the Physicians Crisis committee. The PCC's mission was to help alleviate the malpractice insurance situation, which left 3,500 doctors in the Detroit area uninsured. He went on to become active in the Wayne County Medical Society, serving as president in 1985-86.

Then and now, Doctor McCabe views his leadership roles within organized medicine as fulfillment of his basic responsibility as a physician, which goes far beyond treating individual patients.

"Doctors need to speak up about issues that affect our fellow man in the aggregate," he says, "as opposed to just treating individuals."

Going for the Gold

John Lehtinen, MD, northern Michigan physician, leads the medical team for U.S. Olympic Training Camp.

By William Kendy

ichigan's Upper Peninsula conjures up images of vast forests, pristine lakes, waterfalls and wildlife. It's also the home to one of the four US Olympic Training Camps and John Lehtinen, MD, of Marquette, head physician for the US Olympic Team.

Established in 1985, the US Olympic Education Center at Northern Michigan University is the only center where elite athletes can continue their education while training for the Olympics. Training programs include the biathlon, boxing, cross country skiing, luge, ski jumping, and short

track speed skating. Between 80 and 100 athletes participate in the program, including such athletes as 1992 speed skate Gold medal winner Cathy Turner.

"Gold is at the end of the rainbow for a champion Olympic team member," says Doctor Lehtinen. "But the reality is most athletes won't reach that ultimate goal. Receiving a college education is a successful component of their lives."

Doctor Lehtinen noted that one of the more unique aspects

of the Northern Michigan University center is the "Adopt an Athlete" program, in which families devote time and friendship to the athletes.

"Many of the athletes are on the road a lot competing either individually or as a team," says Doctor Lehtinen. "Adopt an Athlete" allows families to spend time with an athlete on a regular basis, getting them into a home environment with family support and away from the rigors of competition and school. It's been very successful."

Doctor Lehtinen's relationship with the US Olympic Team began almost a decade ago.

"I started doing sports medicine, was a team physician at Barcelona, Spain and am now the head physician for the Olympic Team," he says.

According to Doctor Lehtinen, his visit to Barcelona was a tremendous experience.

"We worked from six in the morning to eleven at night, for four weeks," noted Doctor Lehtinen. "It was great fun but also hard work."

"Competing on the field of play at the Olympics creates a spirit of good will that transcends everything else that goes on in the world," says Doctor Lehtinen. "It was heartwarming to see how the athletes interacted with each other; they sat at the same tables; they were just people."

Doctor Lehtinen took special interest in security at Barcelona and the degree of media scrutiny of the US athletes.

"The security was incredible. There were armed guards everywhere - tanks, warships, even armed scuba divers," says Doctor Lehtinen. "When the American team had to take a bus to compete, they had an armed escort and helicopters and literally shut down the expressways. Yet, on the other hand, you could walk into a subway, never see an armed guard and nobody had a problem."

"There was intense pressure from the media regarding the American athletes," recalls Doctor Lehtinen. "If an American athlete had a medical problem, however slight, the media was right there probing. They wanted to know everything."

What did Doctor Lehtinen envision for the Atlanta games?



"It's going to be a challenge for everyone, and a lot of it has to do with the heat and humidity." says Doctor Lehtinen. "My goal is to anticipate and prepare for any contingency that occurs, with fall-back systems in place."

Doctor Lehtinen will oversee a staff from his clinic in the USA Medical Olympic Village.

Doctor Lehtinen, originally from the Upper graduated from Michigan Peninsula, Technological University, with a degree in biology. He then decided to become a doctor. After graduating from the Wayne State University Medical School and practicing in the Detroit area, he moved back to his beloved Upper Peninsula in 1980.

"My wife says I packed my bags for Detroit and only unpacked them when I got back to Marquette," says Doctor Lehtinen.

He now directs the family practice unit at Marquette General Hospital and helps train and place family practitioners across the Upper Peninsula.

When he's not practicing medicine, training doctors or administering to Olympic Team hopefuls, Doctor Lehtinen is an avid hockey fan, coach and player.



"I love to play and coach hockey," says Doctor Lehtinen. "I'm at the rink just about every night. It's a great release."

The author is a Holt, Michigan-based freelance writer.

Doctor Lehtinen on site at the Games in Atlanta.

Update from the 1996 Olympic Games, Atlanta:

One week into the 1996 Olympic Games in Atlanta, Michigan's Doctor Lehtinen, head physician for the US Olympic Team, reported to Michigan Medicine that his team of 11 physicians and 32 trainers had administered over 3,000 treatments to American athletes.

Highest profile was Kerry Strug, gymnast whose gutsy one-foot dismount from the vault assured her US team gold and electrified her worldwide audience. "Kerry has been the focus of my attention the past three days (since her ankle sprain on that vault three days earlier)," said Doctor Lehtinen July 26. "I have been updating the media on an ongoing basis." Kerry's ankle was doing well, he said, and a reassessment that afternoon would provide insight into whether she would perform in vault and floor exercise individual competitions the following Monday.

Doctor Lehtinen said the medical team's planning and preparation of athletes, especially for competing in the heat and humidity had paid off and that things were going well. Look for more on Doctor Lehtinen's observations regarding Olympic athletes and their training in a coming issue of Michigan Medicine.

NEWSMAKERS

Douglas R. Woll, MD, is the newly appointed chair. Director Section of the Association of HMOs in Michigan. Doctor Woll is a Troy physician specializing in internal medicine.

Vivian Lewis, MD, Flint pediatrician, received the Gov. George



Romney Lifetime Achievement Award for her extensive community service. Doctor Lewis serves on the Whalev

Children's Community Board, is involved in Family Services and the Flint Institute of Arts. She was the first Flint area female African-American pediatrician and first woman and African-American president of Genesee County Medical Society.

Barbara A. Jahnke, MD, is the new medical director of the Field Neurosciences Institute. Doctor Jahnke is a neurologist and sleep disorders specialist in Saginaw.

Archie Bedell, MD, PhD, will serve as the new medical director for the Family Health Plan of Michigan. He is an associate professor of family practice at Michigan State University and Medical College of Ohio, and an adjunct clinical professor of family medicine at Mercy College of Detroit. Doctor Bedell also is president-elect of the Michigan Academy of Family Practice.

Mitchell Dombrowski, MD, has been named interim chair and chief of obstetrics and gynecology at Hutzel Hospital and Wayne State University of Medicine. He is a specialist in maternal and fetal medicine.

The University of Michigan has named A. Lorris Betz, MD, to



serve as interim dean of the Medical School following the resignation of Giles G. Bole, MD, effective August 1. Doc-

tor Bole has returned to the faculty after serving as dean for the past six years. Doctor Betz has served as executive associate dean of the Medical School and is Crosby-Kahn Professor of Neurosurgery and professor of neuroanatomy in the U-M Departments of Pediatrics, Surgery and Neurology.

The MSMS Student Section held elections for the 1996/1997 vear, unanimously re-electing Lee Benjamin, fourth-year student at Wayne State University School of Medicine, as chair. Also elected were Charlene An, second year student, University of Michigan Medical School, vice chair; Tanya Abbott, fourth year student, Wayne State, secretary; and Peter Watson, second year student, Wayne State, Legislative Affairs Liaison.

The Wayne State University School of Medicine Alumni Association presented 1996 Distinguished Alumni Awards to Lawrence Crane, MD, and Senator John J. Schwarz, MD. Distinguished Alumni Awards are given to WSU medical graduates who have made substantial contributions to humanitarian causes, whose contributions in the health field are outstanding or for service to the School of Medicine.

Cathy O. Blight, MD, will begin her office on the 10-member



Michigan State University Development Board of Directors on October 25, 1996. The University Board of Direc-

tors is the only volunteer organization allowed by the President to seek out private fund raising programs to further University priorities.

Thomas Zuber, MD, Midland family physician, has been named 1996 visiting professor to the Department of Family Medicine at the University of Illinois. In addition, Value Health Sciences of Santa Monica, CA, has appointed Doctor Zuber one of 12 US academic and clinical physicians to establish national guidelines for performance of the hysterectomy and other gynecologic surgical procedures.

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PEOPLE

New Members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Celestine Alipui, MD, Jackson Kiran Balchandani, MD, West Bloomfield

Joseph A. Balog, DO, Waterford Ruggero Battan, MD, Grand Rapids Christopher E. Bruck, MD, Bay City Rebecca L. Brundige, DO, Kalamazoo

Lawrence Burns, DO, Grand Rapids Clifford A. Curtis, MD, Flint Manjul Dixit, MD, Ann Arbor Benjamin E. Dorotinsky, MD, Chelsea

Clifford C. Douglas, MD, Flint Brian K. Esch, MD, Three Rivers John F. Fiederlein, MD, St. Joseph Mark C. Figurski, MD, Wyoming Rodolfo R. Finkelstein, MD, Detroit Karen L. Foulds, MD, Holland Michael Gotlib, MD, West Bloomfield Diana Guerrero, MD, West Bloomfield

Bloomfield
David E. Hagan, MD, Lansing
Thomas M. Hall, MD, Oxford
Robert B. Hix, DO, Grand Rapids
Eddie M. Idress, MD, Wyandotte
Shahid Jamil, MD, Bloomfield Hills
John T. Jones, MD, Portage
John Y. Koh, MD, Southfield
Norman E. Liddell, MD, Kalamazoo
Robert P. Maddock, MD, St. Joseph
H. W. Meinhardt-Hoekman, MD,
Zeeland

David Nadeau, MD, Muskegon David W. Oram, MD, Chebovgan Jean F. Oram, MD, Cheboygan Antoun Oska, MD, Warren Renee Palecek, MD, Kalamazoo Veera J. Patel, MD, Three Rivers Sayyid S. Raza, MD, Essexville Gregory W. Reinhold, DO, Monroe David M. Rogovitz, MD, St. Johns Oren M. Sagher, MD, Ann Arbor Eugene O. Seals, MD, Saginaw Anthony T. Sheridan, MD, Saginaw Eric P. Smith, DO, Plainwell Mark A. Stid, MD, Holland Herman C. Sullivan, MD, Kalamazoo Nilufer Sumer, MD, Fenton Padma Surapaneni, MD, Saginaw G. Renee Thomas-Clark, DO, Saginaw Jerome D. Tobias, MD, Detroit

Jerome D. Tobias, MD, Detroit David A. Vila, MD, Dearborn Dan A. Waxman, MD, Detroit

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Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Muhannad Alajrad, MD, 900 M.L. King Blvd., South Pontiac, MI 48341

Action, Date Taken: License Revoked, Fine -\$5,000.00, 07-03-96

Reason: Lack of Good Moral Character

Name: Robert L. Alexander, MD, 345 Highland Court, Plainwell, MI 49080

Action, Date Taken: Reinstated w/Limited License. Probation concurrent w/limited license, 06-06-96 Reason: None Available

Name: Jimmy w. Brandon, DO, 3413 Hammerberg Rd., Flint, MI 48507

Action, Date Taken: Probation - 2 yrs., 06-06-96 Reason: Criminal Conviction - Drug Related

Name: Keithley E. E. Johnson, MD, Box 452, Detroit, MI 48231

Action, Date Taken: License Revoked, Fine -\$50,000.00, 07-08-96

Reason: Criminal Conviction - Drug Related

Name: Leo F. Klingel, DO, 209 S. Main, P.O. Box 188, Galien, MI 49113

Action, Date Taken: Permanent Surrender of License, Surrender of Controlled Substance and Drug Control Licenses, 07-08-96

Reason: Controlled Substance Violations

Name: Kevin H. Lee, DO, 3814 Jefferson, Midland, MI 48640

Action, Date Taken: License Suspended - 6 mo. & 1 day, Fine \$1,000.00, 07-08-96

Reason: Negligence/Incompetence, Lack of Good Moral Character

Name: Bruce D. McFarland, DO, 2370 Folsom Unit B. Boulder, CO, 80302

Action, Date Taken: Probation, 06-06-96

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Jonathan D. Tunis, MD, 2102 Wyndham Hill Dr., Apt 103, Grand Rapids, MI 49505

Action, Date Taken: License Summarily Suspended, 06-04-96

Reason: Criminal Conviction - Drug Related

Name: Jonathan D. Tunis, MD, 2102 Wyndham Hill Dr., Apt 103, Grand Rapids, MI 49505

Action, Date Taken: Summarily Suspension Dissolved, 06-14-96

Reason: None Available

Name: Marvin E. Vercler, DO, 177 S. Washington St., Constantine, MI 49042

Action, Date Taken: Probation - 1 yr., Fine - \$1,000.00, 07-08-96

Reason: Negligence/Incompetence

Name: Richard A. Weiser, MD, 21216 Haymeadow Dr., Saratoga, CA 95070

Action, Date Taken: License Revoked, Fine -\$5,000.00, 07-03-96

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Martin G. Berian, MD, 13 Victory Way, Lake Placid, FL 33852

Action, Date Taken: License Revoked, Fine - \$1,000.00, 06-10-96

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Leonard Berman, MD, 312 Getzville Rd., Amherst, NY 14226

Action, Date Taken: License Limited, 06-14-96 Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Jimmy W. Brandon, DO, 3413 Hammerber Road, Flint, MI 48507

Action, Date Taken: Summary Suspension Dissolved, 04-22-96.

Reason: None Given

Name: Nathaniel M. Cohen, MD, 5655 East River Rd., Suite 101-207, Tucson, AZ 85750

Action, Date Taken: License Limited, 04-17-96 Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Jasubhai K. Desai, MD, 1675 Kingsway Ct., Trenton, MI 48183

Action, Date Taken: License Revoked - as of effective date of Summary Suspension, 04-05-96

Reason: Criminal Conviction

Name: Hilda A. Habenicht, MD, 9146 4th St., Berrien Springs, MI 49103

Action, Date Taken: License Summarily Suspended, 04-30-96

Reason: Drug Related

Name: Harry S. Haluszka, MD, 2062 Verdun St., Oregon, OH 43618

Action, Date Taken: License Suspended - 6 mo. & 1 day, 05-17-96

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Soren C. Jorgensen, MD, Hillsdale Medical Bldg., 170 South Howell, Hillsdale, MI 49242

Action, Date Taken: Summary Suspension Dissolved, License Suspended - 1 yr., Fine - \$1,000.00, Community Service, 04-17-96

Reason: Criminal Sexual Conduct

Name: Jonathan Levi, MD, 2135 Sheffield Dr., Kalamazoo, MI 49008

Action, Date Taken: Summary Suspension Dissolved, Probation - 3 yrs., Fine - \$500.00, 05-15-96

Reason: Violation of General Duty/Negligence

Name: Benjamin A. Monato, MD, 1643 Shaker

Heights Dr., Bloomfield Hills, MI 48304 Action, Date Taken: Reprimand, Probation - up to 3 mo., Fine - \$500.00, 06-10-96

Reason: Criminal Conviction

Name: David P. Nebbeling, DO, 622 East 38th Street, Davenport, IA 52807

Action, Date Taken: Relicensure Denied, 05-08-96 Reason: None Given

Name: Oguz K. Ramadan, MD, 524 Parke Court, Grand Blanc, MI 48439

Action, Date Taken: Reinstatement Denied, 05-09-96 Reason: None Given

Name: Thomas M. Trueman, MD, 31372 John R, Apt. E, Madison Heights, MI 48071

Action, Date Taken: Reinstated w/Limited Licenseminimum 2 yrs., Probation - Concurrent w/Limited License, 05-09-96

Reason: None Given

Name: Tejinder K. Uppal, MD, 2353 Oakridge, Troy, MI 48098

Action, Date Taken: Reinstated w/Limited License - 2 yrs., Probation - Concurrent w/Limited License, 05-09-96

Reason: None Given

Regional Scientific Meeting

MSMS takes Scientific Meeting on road to Dearborn

MSMS presented a day of Category 1 CME courses in Dearborn April 26 just prior to the opening of the MSMS House of Delegates meeting. Approximately 75 physicians attended the courses at this MSMS Regional Scientific Meeting. Cochairs were Tama D. Abel, MD, Ann Arbor, and Kamran Moghissi, MD, Detroit.



The new exhibit for the MSMS Peer Education Project on Immunizations attracted much attention between courses. The project updates physicians on immunizations theories and practices and trains them to teach their colleagues.



Course topics included immunizations, heart disease, hand and wrist disorders, alternative medicine, computer basics, hormonal and psychological aspects of women's health.



Karen B. Mitchell, MD, Michigan Academy of Family Physicians, was director for the course on lifetime needs for immunization therapy. She also is a member of the MSMS Task Force on Immunizations and the Michigan Department of Community Health Advisory Committee on Immunizations.



Bruce Drukker, MD, chair, Department of Obstetrics/ Gynecology and Reproductive Biology, MSU College of Human Medicine, keynoted the plenary session discussion of young people's motivations today for entering medicine. the session was entitled "Who Will Fill Your Shoes?"

Michael Barbarich, MD

The pathologist who would be president

By Ralph D. Ward

icture this for an action/adventure movie scenario. We open with a young boy in central Europe at the end of World War II. He escapes westward, fleeing hunger and revolution to make his way to the new world. He works hard to gain a medical degree, becomes a world traveler, but retains a strong interest in bringing political freedom back to his homeland. He settles down to practice in the American midwest, but becomes a noted spokesman in Washington and other halls of power for reform in his native country. Powerful forces back home dislike the doctor's views. and on a visit, the secret police spring a trap to catch him. Only a well-planned jail escape and breakneck flight out of the country save him. After the fall of Communism, the country dissolves into warring factions. The doctor strives for conciliation and peace, and his work is so respected that he is drafted from his office in America to run for presidency of his wounded homeland.

Sounds too outlandish to be made into a realistic movie, which is just as well. Because

Michael Barbarich, MD, of Escanaba is too busy with his presidential campaign to take time out for meetings in Hollywood. Doctor Barbarich, a pathologist, and established member of the medical community in Escanaba, has a second career-as candidate for the presidency of Bosnia-Herzegovina in elections set for this fall.

Doctor Barbarich, a quiet, unassuming physician and MSMS member, came to his present international status in a very roundabout, adventurous way. A 14-year old Croatian youth at the end of

WWII, he and his family were driven from their home by Yugoslavian commandos in the struggles

of the Communist takeover. Doctor Barbarich and his brother made their way across Europe into Austria, surviving as best they could in the war-shattered central Europe of 1945.

"For a while we had to survive by eating grass and leaves," recalls Doctor Barbarich, who, after a period in the Displaced Persons camps, was resettled in Argentina. There he spent several years laboring in a brick factory by day, and studying medicine at night. He married, and ultimately gained his medical degree.

His internship years coincided with the 1960s physician shortage in the US and Doctor Barbarich was recruited to come to the United States. He chose to specialize in pathology, and built his career at several locations in the US and Canada.

In the mid-1970s, he was invited to work in Michigan's Upper Peninsula. Northern Michigan appealed to Doctor Barbarich and his family, and he chose to stay.

But there was another side to Doctor Barbarich's life, still rooted in the soil of his native Croatia. Until the fall of Communism, the state of Yugoslavia rode herd over a divided stew of ethnic rivalries and hatreds, offering too many opportunities for the violation of human rights. Doctor Barbarich remained deeply concerned about the people of his homeland, and was an active member of the Croatian expatriate community, writing letters, lobbying support, keeping pressure on political leaders back home. His travels had given him a broad range of contacts both in Croatia and the US, as well as a good knowledge of Spanish and English, plus his native Croat.



Doctor Barbarich

"I was quite involved in political work," recalls Doctor Barbarich. "I wrote articles and spoke on Croatian independence." He also lobbied US government leaders to keep pressure on the Yugoslavian leadership, and became a resource on the subject to key members of the US Congress, including Bob Dole and Ted Kennedy.

After the fall of Communism at the beginning of this decade, Doctor Barbarich's visits to Croatia became more frequent, and his work for Croatian independence more locally-based. However, his efforts also drew the attention of the Yugoslavian government and secret police. For a period Doctor Barbarich received anonymous intimidation, as well as threats to the life of his young son back in Michigan. Local police in northern Michigan found themselves guarding the safety of an international figure threatened by one of the world's toughest spy services. "Fortunately, nothing happened," says Doctor Barbarich.

But the doctor was not so fortunate on one of his visits to Croatia after independence was achieved in 1991. Doctor Barbarich's passport was confiscated, and he was jailed. Through contacts in Bosnia (he can't yet name any names), he was able to escape, and sped to the US ambassador's building, where he sought a new passport. "The embassy staffer I talked to said not to worry, they didn't have any charges to press against me," Doctor Barbarich recalls. "I told them 'You don't know these people, they'll set me up." He got his new passport, and was soon out of the country.

Though the process of independence and liberalization has forged the new nation of Bosnia-Herzegovina, peace in the former Yugoslavia as a whole has proven far more elusive. Doctor Barbarich's growing profile as a peacemaker recently caught the attention of one of the country's most respected political parties, the Croatia Party of Rights. Founded in 1861, this party has held on through decades of war, partition and Communism as a minor, but influential, human rights advocate. Seeking a candidate for the Bosnia-Herzegovinan presidential elections in September, 1996, party leaders hit upon an influential, respected peace advocate, an ultimate dark-horse candidate who happened to be half a world away, living in Michigan's Upper Peninsula.

"I was not even aware that I'd been nominated", says Doctor Barbarich. "It's quite an honor when they think of you 5,000 miles away." He has been back several times this year for campaign visits, and feels honored to be considered for the presidency of Bosnia-Herzegovina. "I've always

talked about the need for ceasefires, and for peace, but they didn't want to listen. Now, I guess they're saying `there's this guy from America talking peace,' so they want me back." Doctor Barbarich holds dual citizenship, so there is not legal impediment to his holding a foreign office, at least not at the Bosnia-Herzegovina end. As to an American citizen running for the presidency of another country, Doctor Barbarich reports that he has had "no problems, so far" with the US State Department.

Although a Barbarich presidency is seen as an extreme long-shot, his party's position as an independent broker could make it a factor in the divisive, often destructive politics of the physician's homeland. "I have an optimistic opinion that I'll get enough votes, if not to be president, then to be a decisive voice in government."

Failing that, Doctor Barbarich remains content with his "day job" as a respected pathologist on the shores of Big Bay de Noc. "I don't think (the campaign) will affect my career," he says.

The author is a Riverdale, MI-based freelance writer.



Doctor Barbarich's campaign sign says "a vote for Miljenko Barbarich is a vote for the rights of the Croats in Bosnia."

Editor's Note:

On July 26, Doctor Barbarich told Michigan Medicine that his candidacy for president of Bosnia-Herzegovina was being taken seriously enough that the leading candidate was attempting to force the Bosnian government to declare Doctor Barbarich's candidacy unconstitutional. Should that be the outcome. Doctor Barbarich said he would not be devastated. "I love living in our beautiful Upper Peninsula," he said.

EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

September

3, 10, Bar-Levay Education Association Ongoing Seminar Series "Working through real losses in patients' lives." Location: Bar-Levay Educational Association. 3000 Town Center, Suite 1275. Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

7, "Myocardial Revascularization: Patient Selection/Treatment Options/Follow-up," presented by the medical staff of the Michigan Heart and Vascular Institute, St. Joseph Mercy Hospital, Ann Arbor. Sponsored by: Blue Cross Blue Shield of Michigan. Location: BCBSM Auditorium, Southfield, MI. Contact: BCBSM Office of Continuing Medical Education, (313) 225-0163. Registration deadline is August 30, 1996. Approved for: 4 hours Category 1 credit. Fee: \$15.

14, 17, Bar-Levav Education Association Ongoing Seminar Series "The therapist's character and its impact on the patient." Location: Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No fee.

18-21, Enhancing Quality and Value in Cardiovascular Care, Second Annual Quality of Care Symposium. Location: Vail Cascade Hotel and Club, Vail, CO. Sponsor: American College of Cardiology, in cooperation with University of Colorado School of Medicine. Contact: EP, American College of Cardiology, PO Box 79231, Baltimore, MD 21279-0231. Approved for: 22 hours Category 1 credit. Fees: \$560 members, \$655 non-members, \$410 residents, technologists, nurses, PA, fellowsin-training. Fees higher after 9/4.

19, The Clinical Determination of Disability for Social Security: Continuing Medical Education Conference. Location: Van Dyke Park Hotel and Conference Center, Warren, Michigan. Sponsors: The Michigan Department of Social Services, Michigan State University College of Human Medicine and College of Osteopathic Medicine. Contact: C. Dunkle (313) 256-2375.

19-22, "Your Passport to the Future in Internal Medicine: Preparing Generalists for the 21st Century." Scientific Meeting, Michigan Chapter, American College of Physicians. Location: Grand Traverse Resort, Traverse City. Contact: Linda L. Balzer, Administrative Assistant, ACP Michigan Chapter, B208 Clinical Center, Cardiology Division, East Lansing, 48824-1313 (517) 432-3415 or 800-247-2485. Approved for: 17 hours Category 1 Credit. Fee: \$200 members, \$225 non-members, \$75 ACP Associates, \$40 medical students. Fees higher after Sept. 12.

26-28, 10th Annual International Workshop on Future Directions in Interventional Cardiology. Location: Fess Parker's Red Lion Resort Hotel, Santa Barbara, CA. Sponsor: American College of Cardiology. Contact: EP, American College of Cardiology, PO Box 79231, Baltimore, MD 21279-0231 (800-253-4636, x695). Approved for: 13.5 Category 1 credit hours. Fee: \$495 members, \$595 nonmembers, \$325 fellows-in-training, residents, nurses, PAs, technologists. Fees higher after Sept. 12.

October

1, 8, 15, Bar-Levav Education Association Ongoing Seminar Series "The therapist's character and its impact on the patient." Location: Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

7-8, Second Annual Cardiology for the Consulting Cardiologist: Balancing Intervention with Enlighteed Medical Therapy. Location: Four Seasons Hotel, Boston, MA. Sponsor: American College of Cardiology. Contact: EP, American College of Cardiology, PO Box 79231, Baltimore, MD 21279-0231 (800-253-4636, x695). Approved for: 12 Category 1 credit hours. Fees: \$445 members, \$505 non-members, \$325 fellows-intraining, residents, nurses, PAs, technologists. Fees higher after 9/ 20.

EDUCATIONAL OPPORTUNITIES

10-12, Cardiology Update 1996. Location: Carmel valley Ranch Resort, Carmel, CA. Sponsor: American College of Cardiology. Contact: EP, American College of Cardiology, PO Box 79231, Baltimore, MD 21279-0231 (800-253-4636, x695). Approved for: 12 hours Category 1 credit. Fees: \$480 members, \$555 non-members. Fees higher after Sept. 26.

10-12, 13th Annual Santa Fe Colloquium on Cardiovascular Therapy: Therapy of Acute and Chronic Myocardial Ischemia. Location: Eldorado Hotel, Santa Fe, NM. Sponsor: American College of Cardiology. Contact: EP, American College of Cardiology, PO Box 79231, Baltimore, MD 21279-0231 (800-253-4636, x695). Approved for: 16 hours Category 1 credit. Fees: \$400 members, \$475 non-members, \$245 fellows-intraining, residents, nurses, PAs, technologists. Fees higher after 9/ 26.

14-16, 1196 International Meeting on ANCA and ANCA-Related Diseases, The 7th International ANCA Workshop. Location: Phillips Hall, Siebens Building, Mayo Clinic, Rochester, Minnesota. Sponsor: Mayo Foundation. Contact: Postgraduate Courses, Section of International Medical Education, Mayo Foundation, Rochester, MN 55905, 1 (800) 323-2688 or (507) 284-8399; Fax (507) 284-0532

22, 29, Bar-Levav Education Association Ongoing Seminar Series "When is a change of psychotherapists clinically indicated." Location: Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

24-26, New Techniques and Concepts in Cardiology. Location: Hyatt Regency Capitol Hill, Washington, DC. Sponsor: American College of Cardiology. Contact: EP, American College of Cardiology, PO Box 79231, Baltimore, MD 21279-0231 (800-253-4636, x695). Approved for: 16 hours Category 1 credit. Fees: \$460 members, \$535 non-members, \$325 fellows-intraining, residents, nurses, PAs, technologists. Fees higher after 10/10.

25-27, Advances in Sonography; Fifth Annual Meeting and Postgraduate Educational Course. Location: The Fairmount Hotel, San Francisco, CA. Sponsor: Society of Radiologists in Utlrasound. Contact: SRU office, 1101 Market Street, 14th Floor, Philadelphia, PA 19107 (215) 574-3183; Fax (215) 923-1737; Email sru@acr.org.

27-31, 48th Annual State-of-the-Art Conference. Presented by the American College of Occupational and Environmental Medicine. This year's theme is "Managed Care &

Occupational Medicine: The Next Generation." The conference will feature 16 postgraduate seminars, 8 concurrent scientific sessions and 22 informal seminar groups. Location: Sheraton Centre Toronto Hotel & Towers, Toronto, Canada. Contact: ACOEM, 55 W. Seegers Rd., Alington Heights, IL 60005, phone: (847) 228-6850, fax: (847) 228-1856.

28-30, Clinical Reviews 1996. Location: Mayo Civic Center, Rochester, Minnesota. Contact: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First St. S.W., Rochester, MN 55905. Phone 1-800-323-2688; Fax (507) 284-0532 Approved for: 20 Category 1 AMA.

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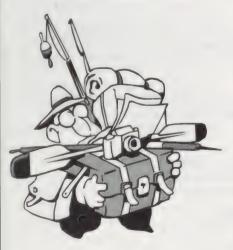
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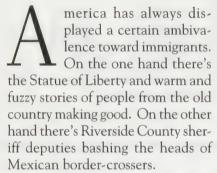
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Pulling up the gangplank

International medical graduates targeted for budget cuts

By W. Peter McCabe, MD



Or closer to home for me, my Irish immigrant grandfather seeing job notices in turn-of-the-century New England with the brutal qualifier. "Irish need not apply". Or my father, a poor Irish Catholic kid who'd clawed and scraped his way through Harvard Law School, being refused a position at a prestigious "Yankee" law firm in Providence, Rhode Island because he hadn't the right social pedigree.

Most of us have stories like this. After all, even Mayflower descendants could be seen as heirs of a bunch of illegal immigrants. But the genius of America is that, with perseverance, hard work and a stiff upper lip, these inequities largely correct themselves and many of us eventually take our rightful places in the mainstream.

At which point many are all too willing to pull up the gangplank, allowing no more on the ship of good fortune. This becomes particularly prevalent during hard times when the competition for a decreasing number of jobs is fierce.

Unfortunately, health care is no exception to the phenomenon. In the frenzy to cut costs, the Health Care Financing Administration (HCFA) proposed eliminating funding for residency positions filled by foreign medical graduates, particularly those already in this country in the middle of ongoing training programs. This proposal was initially included in a bill introduced in the House, although reason prevailed and that onerous provision was eventually removed.

But not before sending shock waves through the medical academic community. If the high quality of the American health system is to be maintained, this country's superb system of post-graduate residency training must be preserved, along with appropriate funding mechanisms. To do otherwise is shortsided in the extreme, threatening to gut the lifeline of future talent.

Particularly offensive in this brief foray into cost-cutting was the attempt to single out international medical graduates for the harshest attention. There's no question that, with downsizing of the residency workforce generally, future



immigration for training purposes will be sharply curtailed. One salutory benefit of this might be a return to what was once a lynchpin of medical immigration policy...the return of highly trained physicians to their native lands where they would elevate the standards of care there.

Even then, however, such a policy would not be without its perile. This country has profited mightily over the decades from the infusion of superb talent from distant lands. A significant percentage of American Nobel prize winners in medicine and other sciences have been foreign-born. It takes considerable courage and strength of character to uproot oneself from the comfort and security of one's homeland, and America has benefited from the continuing infusion of new talents and different perspectives.

Most cogently, such a discriminatory and xenophobic approach is just a plain, flat-out departure from an American sense of fair play.

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Doctor McCabe is MSMS president.

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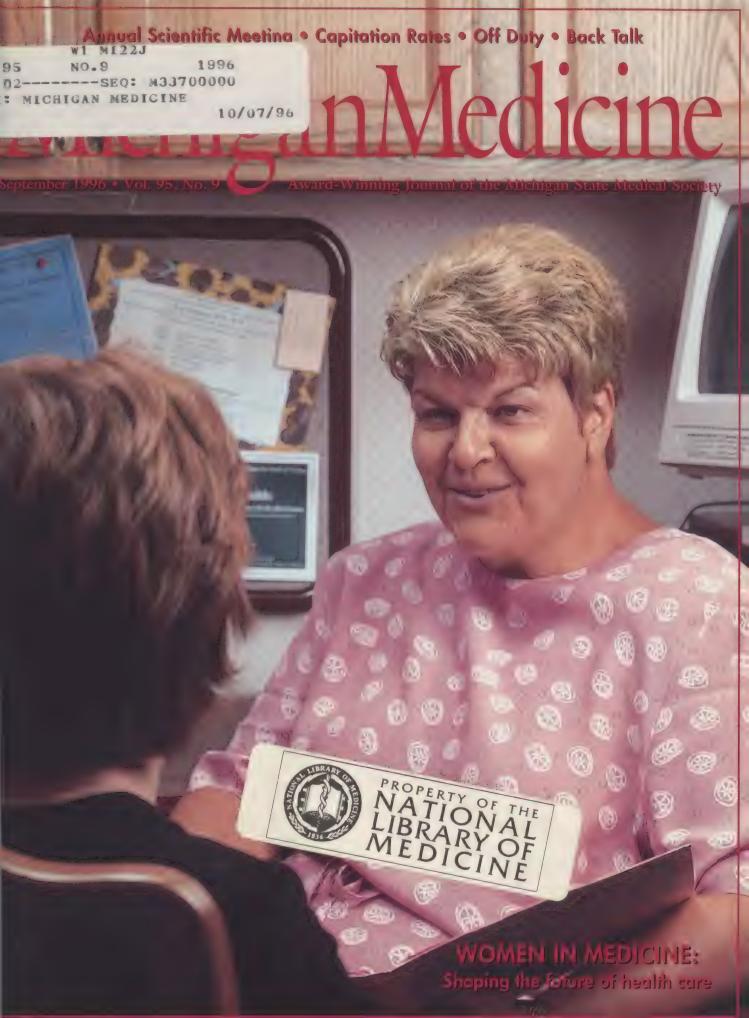
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COVER STORY



Women in Medicine

As the number of female physicians increases, these women are searching to create a balance between their professional and personal lives. Because their role as primary caregiver in the home continues, some women physicians are turning to managed care's consistent schedule to find equilibrium. While the demand for female physicians rises and more women step in to meet this need, will their voices be heard? Key in the debate is Janice L. Werbinski, MD, left, chair of the MSMS Committee on Concerns of Women Physicians and the MSMS Women's Caucus. By Karen Bouffard

Cover photo by: Kim Kauffman

FEATURES

COURSE LISTINGS

MSMS Annual Scientific Meeting

Complete list of courses for the 131st MSMS Annual Scientific Meeting November 14-16 in Lansing allows you to make your selections today. See page three of this month's wrap-around cover to register for courses.

MEDICAL ECONOMICS

Capitated Environment

30

A Survival Primer for Capitated Environment-Part 1

Many physician practices are searching for a starting point on capitation processes in these evolving times of managed care. This article is the first of a two-part series designed to provide Michigan physicians with a framework to approaching capitation.

By Kevin Cawley



September 1996 Volume 95, Number 9

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Physician Activism

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You can help Stop America's Violence Everywhere

MSMS Alliance calls physicians to join in to Stop America's Violence Everywhere. October 9 is SAVE Day in Michigan.

By Janet Gregory

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Equity for international medical graduates in graduate medical education.

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Challenging the Clock

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MSMS member Michael B. Fossel, MD, PhD, publishes new book on telomere research as key to extending life.

By Ralph D. Ward

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Immunizations

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Peer Education Project on Immunizations is training physicians and raising public awareness.

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LETTERS

New immunization chart has eye appeal

To the Task Force on Immunizations:

The "centerfold" from the July Michigan Medicine is wonderful! We post immunization schedule charts in all our exam rooms (30 of them), but ours cannot compete with the eye appeal of the chart you recently pubished. How may we obtain 30 or 40 of these?

Jeanne Baumann, RN

Marquette Family Practice Residency

(Editor's Note: The centerfold chart from the immunizations insert in the July issue of Michigan Medicine has been a solid hit for the Peer Education Project on Immunizations. Thousands of copies have been distributed on request to Michigan physicians' offices following bublication in the MSMS magazine. If you would like to obtain copies of the chart, please call Kathryn Holcomb, coordinator, Peer Education Project on Immunizations, 517/ 336-5707, or email her at kholcomb@msms.org.)

MSMS scores for MOM on Internet home page

I recently received the report on activity through our home page at the MSMS web site. WOW! This report confirms the nature of activity we have received in physician registrations on MOM through our participation in the Internet via MSMS. Please pass along a sincere "thank you" to all MSMS staff and management for their assistance in this great cooperative arrangement.

The dedication of MSMS to the success of the MOM system can't be overstated. Thank you for your commitment to the Michigan Heath Council and to the health care needs of Michigan's communities and the people within them.

Jeff Towns, Director

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editor nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Michigan Medicine reserves the right to accept or reject advertising copy. Products and services advertised in Michigan Medicine are neither endorsed nor warranteed by MSMS, with the exception of a few.

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Question:

What was the best advice vou've ever been given as a physician?

When I graduated from medical school my uncle told me to "keep your chief happy." What he meant by that was not to compromise my ideals or

what was best for my patients, but that as a matter of practical politics I also had to satisfy my superior, his or her requirements and quirks."

Joseph J. Weiss, MD

Detroit Internist

The best advice I was given is from the Hippocratic Oath: "First of all, do no harm, then do good if you can."

Willard S. Stawski, MD

Grand Rapids General Surgeon

A medical school professor once told me, "More than anything, the patient wants to know that his physician cares about him."

Steven A. Sherman, MD

Adrian Neurologist

If you would like to comment on an article in Michigan Medicine, or any other aspect of the magazine, please do not hesitate to contact Judy Marr, Manager, Communications and Professional Relations, at (517) 336-5744, or by FAX at (517) 337-2490, or E-mail at imarr@msms.org

Our goal is to continuously improve Michigan Medicine. We welcome your participation in that process.

The best advice I ever received as a physician was to listen to the patient. This can be interpreted in a global sense to include the history and

physical examination. This advice has held up very well over the years when I faced a diagnostic dilemma and in assessment of therapy.

Dorothy M. Kahkonen, MD

Detroit Internist

The best advice actually came from two people who are former professors of mine. One said that a physician should always do what is in the patient's best interest. It has always been important to me to be a patient advocate. The other one always said it's very important to give some back to the profession in the form of teaching or to participate in a professional organization in order to strengthen or perpetuate the profession.

Kenneth H. Musson, MD

Traverse City Ophthalmologist

Listen to your patients. I also think one of the best pieces of advice I've heard is, "The easiest pain to suffer is the pain of others."

Jeffrey M. Jones, MD

Battle Creek Neurologist

BackTalk is a nonscientific sampling of Michigan physicians' opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to Michigan Medicine, BackTalk, P O Box 950, East Lansing, MI 48826-0950, or fax to (517) 337-2490, or e-mail imarr@msms.org.



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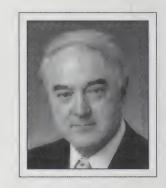
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Durable Power of Attorney for Health Care:

After the Martin decision

By Richard D. Weber, MSMS Legal Counsel



Q: An attorney recently spoke at one of our county medical society meetings. He stated that the Michigan Supreme Court <u>Martin</u> decision rendered ineffective the durable power of attorney for health care in Michigan. Do you agree? Please explain.

A: The applicable section of the Michigan durable power of attorney legislation provides:

"A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

Clearly, the statute requires two conditions: First, the patient must express in a clear and convincing manner that the patient advocate is authorized to make this decision. Second, the patient must acknowledge that such a decision could or would result in the patient's death."

The Michigan Supreme Court in the *Martin* decision established a "purely subjective analysis," rather than a "best interest" standard. Specifically, absent a written directive, only when the pre-injury statements "clearly illustrate a serious, well

thought out, consistent decision to refuse treatment under these exact circumstances, or circumstances highly similar to the current situation, should treatment be refused or withdrawn." Because of this restrictive standard, some attorneys have suggested that the durable power of attorney document should provide the exact circumstances under which the withholding or withdrawing of treatment is authorized. Some attorneys have also suggested that the statute should be amended.

It is my opinion that any document that complies with the statute will be enforceable, notwithstanding the <u>Martin</u> decision. For life support decisions, the document must satisfy the two conditions of the statute.

The printed durable power of attorney for health care form has optional language with the requirement that the patient sign this particular section separately if the patient elects to grant this authority:

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die and I acknowledge such decisions could or would allow my death.

This statement satisfies the two statutory conditions. There is a following space where the patient can more specifically express his/her wishes. Many attorneys have suggested even prior to the *Martin* decision that pa-

tients be more specific in this designation. For example, the authorization could be granted only if the patient is in an irreversible coma, persistent vegetative state or terminally ill. The unique circumstances in the Martin case probably would not fit this conditional authorization. Therefore, the patient should not put conditions on the patient advocate in making decisions to withhold or withdraw treatment without being fully informed that the patient advocate could not act if those conditions were not present. This involves informing the patient in executing a durable power of attorney for health care as to the consequences of limiting the authority of the patient advocate. It does not involve amending the legislation or changing the standard form.

The Supreme Court recognized that a patient's written directive is preferable, but affirmed the arguments asserted by MSMS in its *amicus curiae* brief that oral statements could also be the basis for establishing the "clear and convincing evidence" standard. This decision reversed the ruling of the trial

(continued on page 62)

Editor's Note: If you have legal questions you would like answered by MSMS legal counsel in this column, jot them down and send them to Judith Marr, Editor, P.O.Box950, East Lansing, MI 48826-0950.

"The doctor said Bayer discovered the medicine in my Adalat CC twenty years ago!

Guess he didn't switch me from Procardia XL®* just to save me money."

From Bayer

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In 1972, Bayer scientists discovered nifedipine. Today, the Adalat® brand of nifedipine is available from Bayer in several formulations around the world.

In the United States, the one to prescribe is Adalat® CC. And thousands of physicians have been doing just that—more than 10 million prescriptions have been dispensed since its introduction in 1993.

Blood pressure reduction provided by Adalat CC is comparable with Procardia XL.^{2,2,3} The frequency and type of side effects reported with Adalat CC are typical of dihydropyridine calcium channel blockers.⁴

Adalat CC is not indicated for angina. It should be taken on an empty stomach. As with all distinct pharmacologic entities,

switching from one to another may necessitate careful titration and patient monitoring.

The pricing differential remains—initial doses of Adalat CC are 29% less than the Average Wholesale Price (AWP) for Procardia XL. ¹⁵

Adalat CC from **Bayer**.

People are spreading the word.

Please see next page for a brief summary of Prescribing Information.

^{*}Procardia XL (nifedipine) is a registered trademark of Pfizer Labs Division, Pfizer Inc.

[†]Calculations based on suggested Average Wholesale Price (AWP).⁵ AWP is from a published price list and may or may not represent the actual price to pharmacists or consumers.

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30mg, 60mg & 90mg

Real Value for Real People with Hypertension

BRIEF SUMMARY
CONSULT PACKAGE INSERT FOR FULL PRESCRIBING
INFORMATION For Oral Use

PZ500025BS

INDICATION AND USAGE: ADALAT CC is indicated for the treatment of hypertension. It may be used alone or in combination with other antihypertensive agents.

Soin: In may be used once in troumlation with other limiting release agents.

CONTRAINDICATIONS: Known hypersensitivity to nifedipine.

WARNINGS: Excessive Hypotension: Although in most potients the hypotensive effect of nifedipine is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial fittration or at the time of subsequent upward desage adjustment, and may be more likely in patients using concomitant beta-blockers.

likely in patients using concomitant bete-blockers. Severe hypotension and/or increased fluid volume requirements have been reported in patients who received immediate release capsules together with a beto-blocking agent and who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of nifedipine and a beto-blocker, but the possibility that it may occur with nifedipine alone, with low doses of fentanyl, in other surgical procedures, or with with other narrotic anal-gasics cannot be ruled out. In nifedipine-treated patients where surgery using high dose fentantyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient lime (or least) 36 hours) should be allowed for nifedipine to be worshed out of the body prior to surgery.

Increased Angine and/or Myocardial Infarction: Rorely, potents, particularly those who have severe obstructive coronary artery disease, have developed well documented increased frequency, duration and/or severity of angine or acute myocardial infarction upon starting nifedipine or at the time of dosage increase. The mechanism of this effect is not established.

Beta-Blocker Withdrawat: When discontinuing a beta-blocker it is important to taper its dase, if possible, rather than stopping abruptly before beginning nifedipine. Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Inflintino of "infedipine" angina, procapary reactive to increases sensimity to carecinountines, innument or interapine interestment will approximate proposed to increase it.

Congestive Heart Failure: Rarely, patients (usually while receiving a beta-blocker) have developed heart failure after beginning infedigine. Patients with hight aortic stenosis may be at greater risk for such an event, as the unloading effect of infedigine would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the partic valve.

Flow across the aortic valve.

PRECAUTIONS: General - Hypotensien: Because nifedipine decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and
titration of ADALAT Ct is suggested. Gose observation is especially recommended for patients
already taking medications that are known to lower blood pressure (See WARNINGS).

Peripheral Edema: Mild to moderate peripheral edema occurs in a dose-dependent
manner with ADALAT CC. The placebo subtracted rate is approximately 8% at 30 mg, 12%
at 60 mg and 19% at 90 mg daily. This edema is a localized phenomenon, thought to be
associated with vasodilation of dependent arteriales and small blood vessels and not due
to left ventricular dysfunction or generalized fluid retention. With patients whose hyper
tension is complicated by congestive heart failure, care should be taken to differentiate
this peripheral edema from the effects of increasing left ventricular dysfunction.

Information for Patients: ADALAT Ct is no extended release tablet and should be
swollowed whole and taken on an empty stomach. It should not be administered with
food. Do not chew, divide or crush tablets.

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of

tood. Do not chew, divide or crush tablets.

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted. The relationship to nifedipine therapy is uncertain in most cases, but probable in some. These aboratory abnormalities have rarely been associated with clinical symptoms; however, cholestosis with or without journatice has been reported. A small increase (<5%) in mean alkaline phosphatase was noted in patients treated with ADALAT CC. This was an isolated finding and it rarely resulted in values which fell outside the normal range. Rare instances of allergic hepatitis have been reported with miedipine treatment. In controlled studies, ADALAT CC did not odversely offest serum unic acid, glucose, cholesterol or potossium.

ADALAI Ct did not adversely aftest serum unic acid, glucose, cholesterol or potossum. Nifedipine, like other calcium channel blockers, decreases platelet aggregation in vitra. Limited clinical studies have demonstrated a moderate but statistically significant decrease in platelet aggregation and increase in bleeding time in some nifedipine potients. This is thought to be a function of inhibition of calcium transport across; the platelet membrane. No clinical significance for these findings has been demonstrated. Positive direct Coombs' test with or without hemolytic anemia has been reported but a causal relationship between rifedipine administration and positivity of this laboratory test, including hemolysis, could not be determined.

Although infeligine has been used safely in patients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, rare reversible elevations in BUN and serum creatinine have been reported in patients with pre-existing chronic renal insufficiency. The relationship to infeligine therapy is uncertain in most cases but probable in some.

Drug Interactions: Beta-adrenergic blocking agents: (See WARNINGS).

ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placebo-controlled clinical trial. However, there have been accessional literature reports suggesting that the combination of infedipine and beta-adrenergic blocking drugs may increase the likelihood of congestive heart failure, severe hypotension, or exacerbation of angina in patients with acradiovascular diseases. Digitalis: Since there have been isolated reports of patients with elevated digoxin levels, and there is a possible interaction between digoxin and ADALAT CC, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing ADALAT CC to avoid possible over- or under-digitalization.

Coumarin Anticogudulatis: There have been rare reports of increased prothrombin time in patients toking coumarin anticoagulants to whom mitelapine was administered. However, the relationship to nifedipine therapy is uncertain.

Quincidine: There have been rare reports of an interaction between quinidine and nifedipine (with a decreased plasma level of quinidine).

Graveliane: 80th the peak plasma level of rifedipine and the AUC may increase in the presence of cimelidine. Rantituline produces smaller non-significant increases. This effect of cimelidine may be medicated by its known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of infedipine. If nifedipine therapy is initiated in a potient currently receiving aimediane, custosis intriation is advised.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Nifedipine was administrations.

system proudany responsable for the Instylans metadoushin of mediume. Interdume metapunis metapu

unique determines in der the most common manufamination seem in notional natural with in uter oxygosure to plenytoin.

There are no adequate and well-controlled studies in pregnant women. ADALAT CC should be used during pregnancy only if the potential benefit justifies the potential risk to the letus.

Nursing Mothers: Nifedipine is excreted in human milk. Therefore, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

and ADVERSE EXPERIENCES: The incidence of adverse events during treatment with ADALAT CC in doses up to 90 mg daily were derived from multi-center placebo-controlled clinical trials in 370 hypertensive patients. Adenold 50 mg once daily was used concomitantly in 187 of the 370 patients on ADALAT CC and in 64 of the 126 patients on placebo. All adverse events reported during ADALAT CC therapy were tabulated independently of their causal relationship to medication.

mer cousal retationship to medication.

The most common adverse event reported with ADALAT® CC was peripheral edema. This was dose related and the frequency was 18% on ADALAT CC 30 mg daily, 22% on ADALAT CC 60 mg daily and 29% on ADALAT CC 90 mg daily versus 10% on placebo. Other common adverse events reported in the above placebo controlled trials include: Headache (19%, versus 13%, placebo incidence); Plushing/heat sensation (4%, versus 0% placebo incidence); Dizziness (4%, versus 2% placebo incidence); Dizziness (4%, versus 2%) placebo incidence); Dizziness (4%, versus 2%) placebo incidence); Dizziness (4%, versus 3%) placebo incidence); Dizziness (4%, versus 4%) placebo incidence); Dizziness (4%, versus 5%) placebo incidence); Dizziness (4%), versus 4% placebo incidence); Dizziness (4%), versus 5% placebo incidence); Dizziness (4%),

Where the frequency of adverse events with ADALAT CC and placebo is similar, causal relationship cannot be established.

The following adverse events were reported with an incidence of 3% or less in daily doses up to 90 mg:

Body as a Whole/Systemic: chest pain, leg gain Central Nervous System: paresthesia, vertigo Dermatologic: rash Gastrointestinal: constipation Musculoskeletal: leg cramps Respiratory: epistaxis, rhinitis Urogenital: impotence, urinary frequency

Other adverse events reported with an incidence of less than 1.0% were

Other adverse events reported with an incidence of less than 1.0% were:

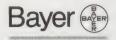
Bady as a Whole/Systemic: cellulitis, chills, facial edema, neck pain, pelvic pain,
pain Cardiovascular: atrial fibrillation, bradycardia, cardiac arrest, extrasystole,
hypotensian, palpitations, phlebitis, postural hypotensian, tachycardia, cutaneous angectases Central Nervous Systems anxiety, confusion, decreased libido, depression,
hypertonia, insomnia, somnolence Dermatologic: pruritus, sweating
Gastrointestinal: badrominal pain, diarrhea, dy mouth, dyspepsia, esophagits, flatulance, gastrointestinal hemorrhage, vomiting Hematologic: lymphadenopathy
Metabolic: gout, weight loss Musculoskeletat: cribralgia, arthrist; myalgia
Respiratory: dyspnea, increased cough, rales, pharyngitis Special Senses: abnormal vision, amblyopia, conjunctivitis, diplopip, linnitus Uragenital/Reproductive:
kidney cakulus, nocturia, breast engargement

The following adverse events have been reported rarely in patients given nifedipine in other formulations: allergenic hepatitis, alapecia, anemia, arthritis with ANA (+), depression, erythromelalgia, extoliative dermatifis, tever, gingival hyperplasia, gynecomostia, leukopenia, mood changes, muscle cramps, nervousness, paranoid syndrome, purpura, shakiness, sleep disturbances, syncope, taste perversion, thrombocytopenia, transient blindness at the peak plasma level, tremor and uritaria.

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5. Redbook Update. Montvale, NJ, Medical Economics Data, Inc., June 1996.



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SURFING THE INTERNET

'Nanobucks'

Make shopping on-line a virtual reality

By William R. DeCourcy, Jr.

One of the most controversial aspects of life online is the issue of Internet commerce. Several different organizations standards developing for "nanobucks," or another payment method that will allow safe and secure financial transactions to take place over the 'net.

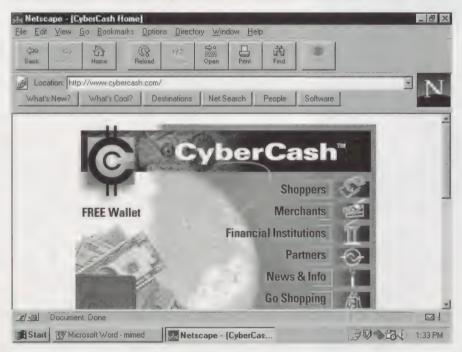
Most Internet users are justifiably nervous about revealing credit card information while online. The potential for abuse exists, and fraudulent online transactions have both consumers and merchants looking for a new virtual banking system. Five current, major systems use a combination of smart banking cards, credit cards, id codes, checking account numbers and PIN numbers to all but insure money changes hands over the 'net securely.

First Virtual Bank (http:// www.fv.com) deducts a sum from your credit card off - line, and provides you with an id number that can be used to access that sum on the Internet. Cybercash (http:// www.cybercash.com) requires each user to open a special bank account

"Surfing the Internet" is a monthly feature of Michigan Medicine. If you have a question regarding the Internet, the MSMS home page, MSMSNET, or Voyager Information Services, contact William R. DeCourcy at MSMS via E-mail at bdecourcy@msms. org or by phone at (517) 336-7601.

containing funds to be used on the Internet. These funds are transferred into the accounts of virtual merchants after an online purchase is authorized by the buyer. Netbill (http://www.ini.cmu.edu/ netbill/) functions in much the same way as Cybercash, using a special bank account to access funds for use on the 'net. Digicash (http:// www.digicash.com) uses a more complicated money distribution system; virtual coins are purchased from affiliated banks and used to buy products or services over the Internet. Each of the coins has an associated serial number, which insures it is only spent once. Similar to Digicash, Millicent (http:// www.research.digital.com/SRC/ millicent/) uses a virtual money system for buying "script" from brokers on the net. These virtual bills can then be used to make online financial transactions.

It is likely that one standard will emerge from the current competition, enabling every Internet user and Internet merchant to do business. Until a unifying standard is adopted, however, each of these systems will add an additional level of financial security on the Internet.



CyberCash is one of several organizations fighting for your online bank account

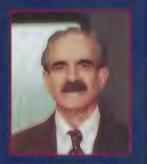
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MSMS Meetings

October

10-11, MSMS Physician Executive Leadership Institute, "Matching Physician Needs to Market Opportunities." Location: University of Michigan, Ann Arbor. Contact: Julie Lester at MSMS at (517) 336-5768.

17, The Physician's Role in an Unparalled System of Change Seminar. Location: University Club, Flint. Contact: Jeanne Blake at MSMS at (517) 336-5776.

November

14-16, 131st MSMS Annual Scientific Meeting. Location: Lansing Center, Lansing. Contact: Patty Bokovov at MSMS at (517) 336-7729.

20, Board of Directors meeting. Location: MSMS Headquarters, East Lansing. Contact: Irene Frost at MSMS at (517) 336-5734.

January 1997

15, MSMS Board of Directors Meeting. Location: MSMS Headquarters, East Lansing. Contact: Irene Frost at MSMS at (517) 336-5734.

AMA Meetings

October

30-November 1, "Family Violence: Building a Coordinated Community Response." Location: Oak Brook Hills Hotel, 3500 Midwest Road, Oak Brook, IL. Contact: Martha Witwer, AMA, (312) 464-5913

December

8-11. American Medical Association Interim Meeting. Location: Atlanta, Georgia, Contact: Judy Marr at MSMS at (517) 336-5744.

Michigan Specialty **Society Meetings**

October

10-13, 40th Anniversary ASIM Annual Meeting. Location: The Westin Hotel, Downtown Chicago. Contact: ASIM, 1-800-338-2746, ext. 261.

November

6, Michigan Dermatological Society Regional Scientific Meeting. Location: Wayne State University, Detroit. Contact: Jennifer Anibal at MSMS at (517) 336-7595.

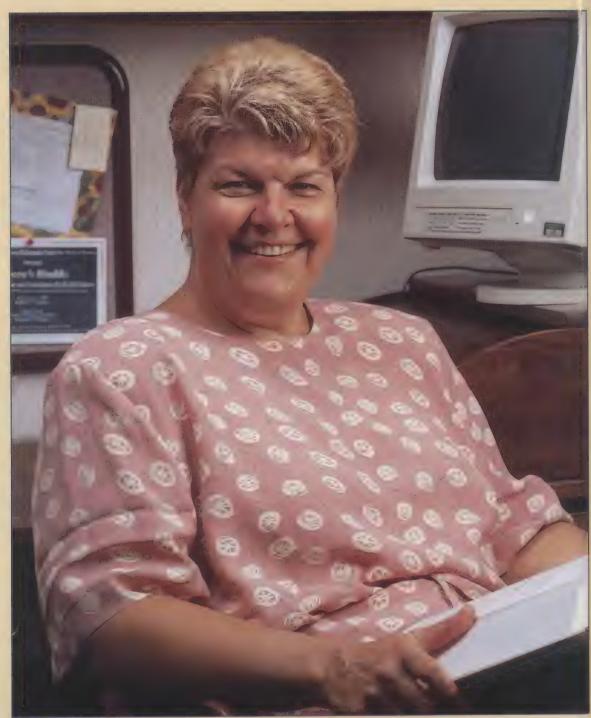
7, Michigan Society of Pathologists Meeting. Location: Dearborn Inn. Dearborn. Contact: Melissa K. Wiegand at MSMS at (517) 336-7586.

December

4, Michigan Dermatological Society Regional Scientific Meeting. Location: Wayne State University, Detroit. Contact: Jennifer Anibal at MSMS at (517) 336-7595.



WOMEN IMEDICINE



Janice L. Werbinski, MD

Shaping the future of healthcare

s the number of female physicians increases, these women are searching to create a balance between their professional and personal lives. Because their role as primary caregiver in the home continues, some women physicians are turning to managed care's consistent schedule to find equilibrium. While the demand for family practice physicians rises and more women step in to meet this need, will female physicians' voices be heard?

Women in Medicine

Shaping the future of healthcare

By Karen Bouffard

hen Dawn Springer, MD, a family practice physician with Temple Medical Associates, Mason, entered medical school at the University of Michigan in 1962, she was one of 17 women in her class of several hundred incoming students. Forced to withdraw for lack of money, she entered MSU's College of Human Medicine 13 years later as a second-year transfer student.

"I had a three-year-old baby, a husband and a dog," deadpans Doctor Springer, 56, who completed her family practice residency at Sparrow Hospital in 1980. "I was very fortunate."

Women entering medical schools this year will experience a world of medicine quite foreign to the healthcare environment of the 1960's and '70s. Fifty-four percent of 1996 admissions to MSU's College of Human Medicine are women. While just 25 percent of medical school faculty

are female, several US medical colleges have neared or achieved gender parity among students. Eleven enroll a majority of women. According to statistics published in JAMA, 41.4 percent of family practice residents, 56 percent of OBGYN residents and 61 percent of pediatric residents are female.

These women are entering medicine at a time of unprecedented change, characterized by the very social and eco-

nomic upheaval that has allowed their entry, as well as by the introduction of managed care. Their unique characteristics as female physicians add to the mix yet another dynamic that is profoundly shaping the future of healthcare.

Like Doctor Springer, most female physicians practice primary care, the field of medicine with the greatest demand for

physicians.

In Michigan, 67 out of 83 counties are Designated Health Professional Shortage Areas, defined as areas with less than one physician per 1,000 people. According to Anne Rosewarne, president of the Michigan Health Council, the predominance of women in primary care specialties, coupled with this shortage of primary care physicians, has resulted in a need for communities and employers to become more attractive to female physicians by addressing their special issues.

According to Nelson Tilden, PhD, president of Medical-Search Institute of Overland Park, Kansas, 88 percent of female physicians have children, and some are single parents. Typically, their husbands are also professionals who may require job-finding assistance if the physician relocates. Women need excellent child care assistance; a flexible and understanding work environment; and may need part-time or job sharing positions.

Addressing a July 25 workshop on recruitment and retention of physicians, sponsored by Medical Opportunities in Michigan (MOM), an organization that seeks to fill the gaps in Michigan's underserved communities, Doctor Tildren told participants: "Recruitment success today (and even more tomorrow) will depend upon your ability and readiness to recruit women physicians."

According to Doctor Springer, "Women tend to be very nurturing and involve patients in mak-

Doctor Springer



ing their own health care decisions. They bring to medicine an enhanced awareness of the importance of the doctor/patient relationship."

Doctor Springer notes that many characteristics of today's female physicians are not unique to women, but can be more generational than gender-specific. "The new 'generation X' people coming along are realizing that there are other things in life to do. They're not going to devote their whole life to medicine. There's a different value system now."

While many characteristics of female physicians are common to young physicians both male and female, they are often experienced more strongly by women. "Women have special needs," according to Ms. Rosewarne, "because they're still the primary caregiver at home."

To fill the need for a reasonable work week of 40-50 hours, a predictable schedule and predictability of call, many women are choosing to become employed physicians. Yet the demands of managed care have raised questions about the productivity of women physicians whose unique practice style often includes spending more time with patients.

Cathy Blight, MD, a pathologist with Hurley Medical Center in Flint, MSMS Board Member and Vice Chair of the Michigan Delegation to the AMA, says there needs to be more study of the effects of spending extra time with patients. "Maybe in the long run these patients won't come back as often, because of appropriate referrals, or because of uncovering an underlying psychological problem."

Doctor Blight adds, "If you try to run medicine like a production line you're going to make some assumptions that a certain procedure takes three or four minutes - - and there are going to be differences. You can't measure the worth of a physician by saying that because one physician sees more patients, this is a better physician."

According to Doctor Springer, physicians learn to balance their desire to spend time with their patients with the realities of their practices. She



Doctor Blight

notes, "If you're spending more time with your patients, you're probably putting in a longer day.

"My productivity has always been good because I've always been in private practice, and have been aware of the financial aspects. You have to bring in patients in order to support an efficiently run practice.

"Women can still retain their skills - - being caring as well as delivering cost effective good medical care - - but with an awareness of what's good business sense."

As the number of female primary care physicians increases, their role as 'gatekeepers' within managed care becomes more significant. Coupled with womens' characteristic style of spending more time with patients, is the increase in primary care physicians' performance of procedures that would once have been referred out to subspecialists. Add to that the increasing number of physicians working part-time or limiting their work week to 40 to 50 hours, and the effect is that more physicians will be required to fill vacancies created by older, male physicians as they leave practice.

According to leff Towns, director of MOM, projections show that 1.5 new physicians will be required to replace each physician that leaves practice. Doctor Tilden's figures show that 25

Women need excellent child care assistance; a flexible and understanding work environment; and may need parttime or job sharing positions.



Doctor Abel

"Women have special needs because they're still the primary caregiver at home." -Anne Rosewarne

President of the

Michigan Health

Council.

percent of all currently practicing family practice physicians are now over age 60; and more than 15,000 vacancies in family practice already exist. As women emerge as the predominant gender in primary care, in the context of such increased demand, will their voices be heard within the establishment of organized medicine?

Women currently represent only about 10 percent of the MSMS House of Delegates, according to Kalamazoo obstetrician/gynecologist Janice L. Werbinski, MD, chair of the MSMS Committee on Concerns of Women Physicians as well as the MSMS Women's Caucus.

While Doctor Werbinski admits women's perception of the 'old boys club' within organized medicine contributes to their limited inclusion, she also notes other impediments women face to becoming involved. Barriers include child bearing and caring. Active female physicians are older women whose children are grown.

"Women don't feel they have a voice, or any power in organized medicine. Often a stance will be taken on an issue, when in fact that view isn't shared by everyone. There is a need to hear all sides of the issues."

Adds Tama D. Abel, MD, family practice physician with Maple Urgent Care in Ann Arbor, "We certainly have more women in leadership positions than we had 20 years ago. It's not that women aren't welcome, it's that they choose to spend time with their families. It's harder to recruit women at almost every level because of that."

Doctor Blight believes that technology may offer some solutions to the difficulties women experience in balancing their many roles as female physicians.

"We have to move into new technologies, and find other ways for people to get involved. Often, women say 'no' because the time of the involvement doesn't fit with their schedule. I can set time for a conference call more easily than I can take two days out for a trip to Washington

"Technology may change when and how we practice medicine. It may be possible for a woman to practice more from her home, with a modem and E-Mail. Who knows where all that's going to lead us?"

According to Ms. Rosewarne, it is expected that gender parity among physicians will occur in the year 2035.

Adds Doctor Blight, "When there's parity, medicine will have changed enough that women with kids may opt to work in alternative practice arrangements that we can't even fathom at this point in time.

"We are being absorbed in a very broad sweep of change. The days of Marcus Welby are over."

The author is a Williamston, Michigan-based freelance writer.

Women's Caucus formed

New forum to serve interest of women physicians

While the number of women physicians has increased dramatically over recent years, women remain underrepresented within the establishment of organized medicine.

According to Janice L. Werbinski, MD, Chair of the MSMS Committee on Women Physicians, just 10 percent of the MSMS House of Delegates are women.

"Women don't get involved in organized medicine," Doctor Werbinski says. "Some are married to men who are members, so they don't think they need to join. Others think it's an 'old boys club' so they don't want to get involved."

Doctor Werbinski adds, "It's a given that women are the child bearers and carers. They will generally put their time with family over their time for a meeting."

Werbinski and other women active in MSMS hope formation of the Women's Caucus at the Spring 1996 House of Delegates meeting will attract more women to participate. The caucus will give members a forum to discuss issues of special interest to women and an opportunity to present a unified voice before the delegates.

The Caucus plans to meet twice per year, the night before the start of the Spring House of Delegates Meeting and during the Fall Scientific Meeting.

At the Spring 1996 meeting the caucus heard presentations by men and women running for MSMS office: reviewed resolutions to be presented at the House of Delegates meeting; and appointed a committee to develop by-laws for the caucus. Caucus members also elected Doctor Werbinski as Caucus chair.

At the Fall meeting the Caucus will approve the bylaws and develop issues to be presented at the Spring 1997 House of Delegates Meeting.

We need more pioneers in leadership roles to bring these issues forward," Doctor Werbinski says. "A lot can be done if we have a loud enough voice."

As women emerge as the predominant gender in primary care, will their voices be heard within the establishment of organized medicine?

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Michigan State Medical Society

131st

November 14, 15 & 16, 1996 Lansing Center, Lansing

List of Courses

THURSDAY MORNING, NOVEMBER 14

All courses run from 8:30 a.m. to 12:00 noon with a half-hour break

LEGISLATIVE BREAKFAST, 7:00 A.M. (NO CHARGE)

Join MSMS for breakfast on November 14, 1996, 7:00-8:15 a.m. as we recognize legislators and leadership in the medical community. James K. Haveman, Jr., Director, Michigan Department of Community Health as well as praised champion of tort reform, Representative Joe Porreca (D-Trenton), and others have been invited to address an intimate gathering just prior to the MSMS Annual Scientific Meeting. For further information regarding this event, please contact Donna W. LaGosh, Chief, Political Affairs or Bryce W.A. Docherty, Assistant, Legislative Affairs at (517) 336-5741.

CHOLESTEROL: PRIMARY AND SECONDARY PREVENTION OF CARDIOVASCULAR DISEASE

PRESENTED BY: American Heart Association: Michigan Affiliate

The purpose of this course will be to review recent information of practical importance to the treating physician on the identification, evaluation, and treatment of patients with or without cardiovascular disease, who have lipid abnormalities. It will include: 1) Identification of the difference between primary and secondary prevention; 2) Review of national cholesterol education program; 3) Review of trials and primary and secondary lipid disorders and their treatment; 4) Review of dietary and pharmacologic treatments; 5) Review of future developments, anticipating the treatment of lipid disorders in the next several years.

COURSE DIRECTOR: Joel K. Kahn, MD, FACC, FACP, Staff Cardiologist, William Beaumont Hospital, Trov

PRESIDING: Doctor Kahn



FEMALE URINARY DYSFUNCTION

PRESENTED BY: MSMS Committee On Concerns Of Women Physicians

This course will provide primary physicians with increased sensitivity and strategies to help women with intrastitial cystitis. Comprehensive assessment; medical, behavioral, and surgical management will be discussed. Indications for psychiatric referral will be covered.

COURSE DIRECTOR: Cassandra M. Klyman, MD, Past-President, Michigan Psychiatric Society, Bloomfield Hills

PRESIDING: Doctor Klyman

FREQUENTLY ENCOUNTERED NEUROLOGICAL PROBLEMS

PRESENTED BY: Department of Neurology, Wayne State University School of Medicine This course will provide practical information about frequently encountered neurological problems for primary doctors and emergency physicians. The presentations will include stupor and coma, headache, status epilepticus and stroke. Attendees will develop an understanding of the diagnosis and current treatment of these common illnesses. Recent advances in therapy will be emphasized and discussed.

COURSE DIRECTOR: Paul A. Cullis, MD, Clinical Associate Professor, Department of Neurology, Wayne State University School of Medicine

PRESIDING: Doctor Cullis

IMMUNIZATIONS FOR A LIFETIME

PRESENTED BY: Michigan Academy of Family Physicians

This course will provide physicians with the current immunization recommendations for children, adolescents, adults, and the geriatric population. Emphasis will be on recent changes. Information about immunizations for special populations, including health care workers and international travelers, will be included. Methods to improve effective immunization practices will be discussed.

COURSE DIRECTOR: Karen B. Mitchell, MD, Faculty, Family Practice Residency, Providence Hospital, Southfield

PRESIDING: Doctor Mitchell

STRESS MANAGEMENT SKILLS FOR PHYSICIANS

PRESENTED BY: Michigan Heart and Vascular Institute, Ann Arbor.

The purpose of this course is to discuss the unique stressors that physicians experience in their professional lives and the effects these stressors can impose on the physician-patient relationship. It will then discuss techniques of stress management that physicians can use, with the ultimate goal of improving the physician-patient relationship.

COURSE DIRECTOR: Errol E. Erlandson, MD, Medical Director of Wellness, Michigan Heart and Vascular Institute

PRESIDING: Doctor Erlandson

WHAT'S NEW IN GENERAL SURGERY

PRESENTED BY: Department of Surgery, Wayne State University School of Medicine

This course will review for primary and consulting physicians newer concepts in four areas of general surgery. Presentations include current controversies in the treatment of breast cancer, newer concepts in the treatment of trauma, and a new means for treatment of gastrointestinal malignancies, photodynamic therapy. The course will conclude with an overview of current understanding of the indications, limits, side effects and future of laparoscopic surgery.

COURSE DIRECTOR: David Fromm, MD, Penberthy Professor and Chairman, Department of Surgery, Wayne State Univ.; Surgeon-in-Chief, Detroit Medical Center; Chief of Surgery, Harper Hospital PRESIDING: Doctor Fromm



THURSDAY AFTERNOON, NOVEMBER 14

All courses run from 1:30 p.m. to 5:00 p.m. with a half-hour break

ADOLESCENT MEDICINE

PRESENTED BY: Children's Hospital of Michigan, Detroit

This course will provide adolescent medicine topics to primary care physicians and other health providers. It will focus on principles recommended by the AMA for several health care issues with respect to prevention and screening (GAPS), eating disorders which includes diagnosis, management and referral as well as a discussion on adolescent sexuality, including risk assessment, ethical and legal issues prevention strategies.

COURSE DIRECTOR: Kathryn Wright, DO, Assistant Professor, Department of Pediatrics, Wayne State University School of Medicine; Department of Adolescent Medicine, Children's Hospital of Michigan, Detroit

PRESIDING: Doctor Wright

OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

PRESENTED BY: Michigan Occupational And Environmental Medicine Association

This course is designed to provide insight and current views of three topics in occupational and environmental medicine. An update on multiple chemical sensitivity will be provided and current research on the respiratory effects of machine oil exposure will be discussed. The final presentation will review the evolving picture of the silicone breast implant issue.

COURSE DIRECTOR: Ron Egedahl, MD, Michigan Occupational and Environmental Medicine Association; Health and Safety Services, Dow Chemical Company, Midland

PRESIDING: Doctor Egedahl

RADIOLOGY FOR CLINICIANS

PRESENTED BY: Michigan Radiological Society

This course will instruct primary and consulting physicians in the efficiency of diagnostic modalities in various areas: a) evaluation of dyspepsia and epigastric pain; and b) osteoporosis. Also, the utility of nuclear medicine in emergent situations will be discussed and an overview of various procedures in interventional radiology will be presented.

COURSE DIRECTOR: A. P. Zingas, MD, FACR, Department of Radiology, Harper Hospital, Detroit PRESIDING: Doctor Zingas

SCREENING AND DIAGNOSIS OF BREAST CANCER: A COURSE FOR PRIMARY CARE PHYSICIANS

PRESENTED BY: Comprehensive Breast Health Clinic, Michigan State University College of Human

This course will provide practical knowledge about breast disease and is designed for primary care physicians. Lectures will cover risk factors for breast cancer, and techniques of screening, followed by a demonstration and hands-on workshop on clinical breast examination. Work up of common breast abnormalities, including presentations of a breast mass, nipple discharge, skin changes, and an abnormal mammogram will also be discussed. The course format uses a standardized curriculum originally developed by the American Medical Women's Association for the Centers for Disease Control (CDC).

COURSE DIRECTOR: Janet Rose Osuch, MD, Associate Professor, Dept. of Surgery, Michigan State Univ. College of Human Medicine; Medical Director, Comprehensive Breast Health Clinic PRESIDING: Doctor Osuch

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STROKE IN THE 1990'S: MAJOR ADVANCES IN ACUTE TREATMENT, DIAGNOSIS AND PREVENTION

PRESENTED BY: Henry Ford Stroke Program, Departments of Neurology and Neurosurgery, Henry Ford Hospital, Detroit

This course is a comprehensive workshop for the family physician/internist on the acute treatment, diagnosis, and prevention of stroke. Strategies for primary care providers include recognizing risk factors and warning signs, as well as providing patient education and effective measures to prevent stroke. The tools necessary for acute stroke intervention and the results of the NINDS t-PA Stroke Trial will be discussed. Recent advances in the surgical management of stroke and patient selection strategies for these therapies will be presented.

COURSE DIRECTOR: Steven R. Levine, MD, Division Head, Cerebrovascular Diseases, Henry Ford Stroke Program, Department of Neurology, Henry Ford Hospital, Detroit

PRESIDING: Doctor Levine

FRIDAY MORNING, NOVEMBER 15

All courses run from 8:30 a.m. to 12:00 noon with a half-hour break Complimentary Coffee available at 7:00 a.m.

7:15 a.m. "Early Bird" Plenary Session

USE AND MISUSE OF BACTERIAL RESISTANT ANTIBIOTICS

H. Gunner Deery II, MD, FACP, FIDSA, President, Michigan Infectious Disease Society, Petosky Antibiotic resistance is becoming an increasing problem. This session will review some of these issues and provide recommendations for appropriate antibiotic use, both inpatient and outpatient.

ASTHMA AND RHINOSINUSITIS: WHEN TO REFER

PRESENTED BY: Departments of Internal Medicine and Pediatrics, Wayne State University School of Medicine and VA Medical Center, Detroit

This course will provide an overview of allergic respiratory disease for the primary care physician. Faculty will then present in-depth material on asthma and rhinitis in adults and children and on childhood sinusitis. Speakers will delineate disease features which suggest the need for subspecialist consultation.

COURSE DIRECTOR: Michael R. Simon, MD, Associate Professor, Departments of Internal Medicine and Pediatrics and Training Program Director, Division of Allergy and Immunology, Departments of Internal Medicine and Pediatrics, Wayne State University School of Medicine PRESIDING: Doctor Simon

ATRIAL FIBRILLATION AND MYOCARDIAL REVASCULARIZATION: MAJOR ISSUES FOR OFFICE BASED PHYSICIANS

PRESENTED BY: Michigan Heart and Vascular Institute, Ann Arbor

This course, designed for primary care physicians, will provide valuable information on the management of patients with two very frequently encountered cardiac problems: atrial fibrillation and myocardial ischemia that may require revascularization. The initial presentation will focus on the most current recommendations for the management, treatment goals and outcome measures for the patient with atrial fibrillation. This will be followed by lectures and discussion relating to the assessment, functional testing, treatment options and follow-up care of the patient who presents with chest pain. The importance of lipid management after revascularization will be included.

COURSE DIRECTOR: Ron J. VandenBelt, DO, Cardiologist, Michigan Heart and Vascular Institute PRESIDING: Doctor VandenBelt



COMMON HAND AND WRIST DISORDERS: DIAGNOSIS AND MANAGEMENT FOR PRIMARY CARE PHYSICIANS

PRESENTED BY: The West Michigan Hand Center, Grand Rapids

This course will outline the diagnosis and treatment regimens for a wide variety of common hand and wrist disorders seen by most primary care physicians. Fractures and dislocations, arthritic conditions, tumors, and occupational disorders will be addressed.

COURSE CO-DIRECTORS: Donald P. Condit, MD, Clinical Assistant Professor, Department of Orthopaedics, Michigan State University College of Human Medicine and Ralph M. Costanzo, MD, Clinical Assistant Professor, Department of Orthopaedics, Michigan State University College of Human Medicine

PRESIDING: Doctors Condit and Costanzo

PEDIATRIC EMERGENCIES

PRESENTED BY: Critical Care Medicine, Children's Hospital of Michigan, Detroit; and DeVos Children's Hospital, Grand Rapids

This course will instruct primary physicians in the recognition and initial stabilization of common emergencies seen in children. The specific topics include the pediatric airway, shock in children, status asthmaticus and the evaluation of coma and seizures in children.

COURSE CO-DIRECTORS: Ashok Sarnaik, MD, Children's Hospital of Michigan, Detroit, and Nabil Hassan, MD, DeVos Children's Hospital, Grand Rapids

PRESIDING: Mary Lieh-Lai, MD, Director of ICU and Associate Professor, Department of Pediatrics, Children's Hospital of Michigan, Detroit

SEXUALLY TRANSMITTED DISEASES (STD)

PRESENTED BY: Department of Obstetrics and Gynecology, Wayne State University School of Medicine, Detroit

Sexually transmitted diseases (STDs) continue to be a major health problem for both men and women, particularly those of younger age groups. The objective of this course is to present current methods of diagnosis and management of common STDs. Specific lectures will present an overview of STDs, evaluation and management of vaginitis and pelvic inflammatory disease. The course is suitable for family physicians, internists, obstetrician and gynecologists, pediatricians, and other interested physicians.

COURSE DIRECTOR: Kamran S. Moghissi, MD, Professor, Department of Obstetrics and Gynecology, University of Michigan Medical School

PRESIDING: Doctor Moghissi

FRIDAY AFTERNOON, NOVEMBER 15

All courses run from 1:30 p.m. to 5:00 p.m. with a half-hour break

ALLERGY AND IMMUNOLOGY UPDATE

PRESENTED BY: Michigan Allergy and Asthma Society

This course will provide both the specialist and primary care physician, an update on the various anaphylactic syndromes and a practical approach to diagnose pediatric immunodeficiency syndromes.

COURSE DIRECTOR: Alan Kwaselow, MD, FACP, FCCP, Chairman, Michigan Allergy and Asthma Society Program Committee, Novi

PRESIDING: Doctor Kwaselow

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COMMON ENT PROBLEMS FOR PRIMARY CARE PHYSICIANS

PRESENTED BY: Michigan Otolaryngological Society

Common conditions of the ear, nose, and throat will be covered by case presentations and didactic lectures, with particular emphasis on practical treatment and indications for referral.

COURSE DIRECTOR: Larry B. Lundy, MD, Program Director, Michigan Ear Institute, Farmington Hills

PRESIDING: Doctor Lundy

COMPUTER BASICS AND INTRODUCTION TO THE INTERNET

PRESENTED BY: MSMS Committee on Technology in Medicine

This introductory computer course will give practicing physicians a strong foundation in computer technology. The first half of the course will concentrate on introducing physicians to computers and explaining their use. The second half of the course will build on this technological foundation to introduce the participants to the Internet. Physicians attending this class will receive Internet access software that will allow them to take immediate advantage of e-mail and World Wide Web research.

COURSE CO-DIRECTORS: David R. Rovner, MD, Chair, MSMS Committee on Technology in Medicine, East Lansing and William R. DeCourcy, Jr., Chief, Internet Systems, MSMS, East Lansing PRESIDING: Doctor Rovner and Mr. DeCourcy

DIAGNOSIS AND MANAGEMENT OF BENIGN ANORECTAL DISEASE

PRESENTED BY: Michigan Society of Colon and Rectal Surgeons

Benign anorectal disease is frequently encountered in the primary care and surgical setting. This course will emphasize the assessment and diagnosis of conditions producing anal discomfort. Presentations will include treatment options for the management of perianal infections, hemorrhoidal disease and perianal dermatological diseases.. This course is supported in part by a special bequest from the estate of Elizabeth T. Sladek.

COURSE DIRECTOR: Eric J. Szilagy, MD, FACS, Senior Staff Surgeon, Division of Colon and Rectal Surgery, Henry Ford Hospital, Detroit; Michigan Society of Colon and Rectal Surgeons PRESIDING: Doctor Szilagy

UNCONVENTIONAL CORONARY RISK FACTORS

PRESENTED BY: Association for Lipid and Atherosclerosis Research in Michigan (A.L.A.R.M.) New information is being rapidly incorporated into clinical practice. Many physicians are measuring homocysteine levels, lipoprotein (a) fibrinogen levels and acting on the results. Some are prescribing modest alcohol or red wine. Is there sufficient evidence to justify these practices? This course will explore the currently available data and mechanism.

COURSE DIRECTOR: Lester Kobylak, MD, General Internal Medicine, Henry Ford Hospital, Detroit PRESIDING: Doctor Kobylak

VIOLENT PATIENTS: CARE AND CLINICIAN SAFETY

PRESENTED BY: Michigan Psychiatric Society

Every Practicing physician faces the possibility of violence during any day. This course describes risk factors and possible scenarios that may embroil the physician in a violent episode. The prediction, management and treatment of the violent person will be discussed using examples from everyday life. By being aware of and able to identify dangerous situations, clinician, staff, and family safety can be maximized. Participants and presenters own case examples will be a focus of discussion.

COURSE DIRECTOR: Seymour Baxter, MD, Psychiatrist, Birmingham; Clinical Faculty, Wayne State University School of Medicine

PRESIDING: Doctor Baxter



SATURDAY MORNING, NOVEMBER 16

All courses run from 8:30 a.m. to 12:00 noon with a half-hour break Complimentary Coffee Available at 7:00 a.m.

7:15 a.m. "Early Bird" Plenary Session

THE WEB AND BEYOND

William F. Bria, MD, Medical Director of Clinical Information Systems, University of Michigan Medical Center This free course, through presentation and demonstrations, will instruct primary and consulting physicians in the integration of the latest information technology into the daily office practice of patient care. The practical value of Internet and WWW technologies will be emphasized as well as current breakthrough applications on Personal Digital Assistants (PDAs) and CD-ROM technologies.

INTERMEDIATE COMPUTERS AND ADVANCED INTERNET INFORMATION

PRESENTED BY: MSMS Committee on Technology in Medicine

This class will present intermediate Internet concepts to physicians who have a strong background using Windows or Macintosh computers. Course topics include new Internet application, using the Internet for teleconferencing, advanced research program and a review of current Internet technologies.

COURSE CO-DIRECTORS: David R. Rovner, MD, Chair, MSMS Committee on Technology in Medicine, East Lansing and William R. DeCourcy, Jr., Chief, Internet Systems, MSMS, East Lansing PRESIDING: Doctor Royner and Mr. DeCourcy

LOW BACK PAIN AND ALTERNATIVES IN MANAGEMENT

PRESENTED BY: Department of Neurosurgery and Department of Orthopaedic Surgery, Henry Ford Hospital, Detroit

This course is a comprehensive workshop for the primary care physician on the diagnosis and management of the low back pain patient. The course will focus on the more common clinical presentations (e.g., spinal stenosis, ruptured disc, degenerative and traumatic instability) and review their management evaluations and outcomes. These sessions will involve specific patient scenarios illustrating various diagnostic issues.

COURSE DIRECTOR: Russ P. Nockels, MD, Director, Spine & Trauma Surgery Program, Department of Neurosurgery, Henry Ford Hospital, Detroit

PRESIDING: Doctor Nockels

MANAGEMENT OF THE RED EYE IN THE PRIMARY CARE PRACTICE

PRESENTED BY: Michigan Ophthalmological Society, East Lansing

This course presents the differential diagnosis and management of the red eye and other common ocular disorders. Emphasis will be placed on clinical pearls that allow the primary care physician to appropriately manage and/or triage problems such as red eye, acute visual loss, and ocular manifestations of systemic disease.

COURSE DIRECTOR: George A. Williams, MD, President, Michigan Ophthalmological Society, Livonia; Chief, Vitreoretinal Surgery, William Beaumont Hospital, Royal Oak; Associate Clinical Professor, Biomedical Sciences, Oakland University, Rochester Hills

PRESIDING: Doctor Williams

Register for the 1996 MSMS Annual Scientific Meeting using form on page three of wraparound cover on this issue of Michigan Medicine. More meeting details are available by contacting Sarah Cressman at MSMS, (517) 336-5727, or via email at scressman@msms.org.



SCREENING, DIAGNOSIS AND TREATMENT OF PROSTATE CANCER

PRESENTED BY: Department of Urology, Wayne State University School of Medicine The course will explain the screening methods for prostate cancer, who should be screened and the cost effectiveness of screening procedures. The effectiveness of PSA, digital rectal exam and ultrasound of the prostate in the diagnosis of early prostate cancer will be discussed. The course will address the issue of treatment of prostate cancer. Surgical treatment versus radiation therapy will be discussed. Participants will learn which patients will benefit from surgery and who are the ideal candidates for radiation therapy. The consensus paper from MDCH will be discussed. Finally, the participant will learn about treatment of two major complications of surgery and radiation therapy, namely erectile problems and urinary incontinence.

COURSE DIRECTOR: C. B. Dhabuwala, MD, Associate Professor, Department of Urology, Wayne State University School of Medicine

PRESIDING: David P. Wood, MD, Professor, Department of Urology, Wayne State University School of Medicine

TEAM MANAGEMENT OF THE CHILD WITH LEARNING DIFFICULTIES

PRESENTED BY: McLaren Family Practice Residency, Flint

This course will provide primary care physicians with a practical approach to assessing the family which presents a child with difficulties involving learning, attention and other behavior. Through a lecture/ discussion format, the presenters will familiarize the audience with the classification and differential diagnosis of child behavior and learning problems. The physician will learn how to evaluate and develop a treatment plan for each child using community resources, including special education programs, support groups, parents, mental health professionals, and medications when necessary. Case discussions will be used to illustrate individualized treatment. At the end of this course, each participant should be able to perform history, physical and laboratory evaluation to determine appropriate course of treatment.

COURSE DIRECTOR: Paul Lazar, MD, Director, McLaren Family Practice Residency; Assistant Professor, Department of Family Practice, Michigan State University College of Human Medicine PRESIDING: Doctor Lazar



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Faculty

Robert Frykberg, DPM, MPH - ABPS, FACFAS Clinical Instructor in Surgery, Harvard Medical School 1996 Program Chairman, Am. Diabetes Assn. Foot Care Council Symposium

Carolyn Merritt, MD -

Humana Health Plans, Evanston, Illinois

Lawrence Harkless, DPM - ABPS, FACFAS University of Texas Health Science Center Government Relations Committee, Am. Diabetes Assn.

James Sunstrum, MD -

Infectious Disease Specialist, Oakwood Hospital

E. Dalton McGlamry, DPM - ABPS, FACFAS Founder of The Podiatry Institute Author, Teacher and Lecturer

Dennis Zikowski, MD - ABPM, ABA, NBME Anesthesiologist

Assistant Director, Pain Clinic, Oakwood Downriver Medical Cntr.

Gerard Yu, DPM - ABPS, FACFAS

Examination Committee Chair, Am. Board of Podiatric Surgery North Olmsted, Ohio

Charles Kissel, DPM - ABPS, FACFAS
Dept. of Surgery, Chief, Sec. of Podiatric Surgery, Hutzel Hospital

Francesco Rodriguez, MD -

Vascular Surgeon, Bon Secours Hospital

October 24 - 26, 1996 The Ritz-Carlton, Dearborn

Topics

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- ◆ Manifestations of the Charcot Foot
- Surgical Management of Diabetic Infections
- Pedorthic Management of Diabetic & Charcot Foot
- Diabetic Nerve Pain
- ◆ Diabetic Ulcer Treatment
- ◆ Diabetic Risk for Infections
- ◆ Problem Wounds
- Mycotic Infections of the Diabetic: A Threat or Not?
- ◆ Total Contact Casting
- ♦ Infectious Disease
- ◆ Revascularization: New Techniques
- Diabetic Amputations
- ◆ The Diabetic Patient: A Lawyer's View
- ◆ Pathophysiology of the Diabetic Foot
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Capitation Rates

A Survival Primer for Capitated Environment—Part 1

By Kevin Cawley

his article is the first of a two-part series designed to provide Michigan physicians with a conceptual framework to approaching capitation. Capitation in financing consists of prepaid risk transfers from insurers to providers for cost and utilization of services. Unfortunately, a number of physician practices are searching for a starting point on capitation processes in these evolving times. The focus of this first article is on primary and specialty subcapitation. Global capitation will be covered in a second article.

The framework provided here has six sequential steps. Most physicians' first concern in evaluating capitation is understanding what per member per month (PMPM) rate would represent replacement income. These calculations can be estimated.

Scrutinize revenue stream

Step one is to scrutinize your current revenue stream. At a minimum, to understand a practice revenue stream, the following should be known:

• Annualized frequency of chargeable procedures (ex. office visits, hospital days, etc.).

• The same frequency information by payer (or the most common payers).

• The amounts paid or allowable by payer by chargeable procedure code.

• The amounts charged by chargeable procedure code.

With the information above, calculations of gross and net Patient Service Revenue by payer may be performed using a spreadsheet. A partial set of example spreadsheets is shown as exhibit A. Additionally, if your billing system has the capacity, it would be preferable to obtain more information. Such information would include the number of patients, where they are from (county - or zip code), and ICD-9 diagnosis, and procedure codes, as well as age and sex subsets.

Capitation rates can take an overall form or can be adjusted for age and sex of patients. It is valuable to know if your patients' demographics are similar to any group being proposed for capitation.

Select statistics

Step two is to select appropriate utilization statistics for the population considered for capitation. Invariably, this is where early efforts at capitation have failed. Most of the problem stems

from believing that data for such calculations is either internal, or to be provided by a consulting actuary. In reality, sources of this information are three; and the validity and applicability of each source is a judgment that can be made only in light of the other sources, and with a knowledge for your particular circumstances. Each source has its limits:

Internal data is of the greatest value where a group is so dominant as to control in excess of 90 percent of a market. A good example of this would be a radiology group in a one hospital town (that has little in- and out-migration of patients). The group's data would in all likelihood be the best source of radiology utilization information for the population. Adjustments can be made for in- and out-migration, and for a very limited number of other area providers until the validity of internal data decreases and validity of other sources increases.

The second important source of utilization data is the payer. This is most valuable when the payer has previous experience with the patients that are being considered for capitation. A PPO attempting to move a large employer group from an indemnity product to an HMO is likely to have good utilization data on the insured population. An HMO new to a given market is likely to have slightly less valuable information. Many people

Capitation
rates can
take an overall form or
can be adjusted for
age and sex
of patients.

express a variety of hesitations about even requesting data from payers. Those reasons traditionally have included fear of appearing inexperienced, and that previous requests have met with resistance. For those hesitations consider the following consolations:

- Considering a capitation arrangement without sufficient data is fiducially irresponsible.
- Reputable managed care organizations that want to move to capitation are more than happy to share such information with anyone with whom they want to do long term business.
- The reality behind such comments as, "It's our policy not to share that information," is that it sounds better than, "we either can't or haven't compiled that information."

The last source of such information is the consulting and actuary market. This includes both real-time services and printed manuals. It is a market that is important to tap - even if your other two sources have what appears to be very reliable data. The reason for its importance is that the external data resources provide a reasonableness check on all calculations, and a snapshot of other markets (this might well represent a snapshot of your future). External data sources are not without their own limits, though. Invariably the underlying feeder systems have a variety of erroneous data, the services being considered for capitation may not be identical, there may be significant underlying population demographic differences between the population being considered for capitation and the external data source's database.

Ideally, utilization information should be distilled to annualized individual chargeable (CPT-4) codes per 1,000 population for each service included in the capitation arrangements. For services proposed that are beyond the capability of your practice, consider negotiating carve outs or developing the capability. If the utilization data available is not in the form of utilization of procedures per 1,000 enrollees, consider various estimates to manipulate the data to that form.

Estimate income

Step three is to estimate income in the form of PMPM. Using the spreadsheet tables from the first step add the demographics and extend the tables. To continue with exhibit A, for example, if we run an internal medicine group (ABC Internal Medicine Group) that is currently reimbursed fee-for-service by a local HMO (DEF HMO); and through either our data or payer data we find that we are currently servicing 3,200 members of the HMO; and for services the HMO is including all existing fees less ventilator management services, and that historical fee-forservice revenue was \$409,523 of which \$29,360 was ventilator management service then the comparable PMPM fee for DEF internal medicine would be \$9.90 [(409,523-29,360)/(3,200x12)] in the form of replacement income.

Analyze rates

Step four is to analyze the calculated rate against external and internal benchmarks. From payer data, we might know how it compared to other primary care physicians that practice with the plan. From our own data we should be able to glean how it compares to other payers. If we reviewed more than one year's data, we might get a sense of the variation that might be occurring. In looking at external data, we could find other HMO rates for services in both our market, and more rapidly evolving markets. Depending on how those compare to our example we could use the data for our next step.

Compute adjustments

Step five is computing adjustments to create appropriate risk margins and negotiating positions. With a backdrop of the price at which these services are purchased, an individual physician group can begin to find itself as either a price maker, or a price taker. In general, price makers have been efficient and have been paid

Ideally all decision makers want real-time information in evaluating care decisions.

		dicine Group ue Analysis					
	nded 6-30						
Payer A	Analysis-	DEF HMO					
	OPT 4	D	Ohana	DEE E	DEE VAL	Cores DCD	Net PSR
Code	CPT-4	Desc.	Charge	DEF Fee	DEF Vol	Gross PSR	
1001		NP OV BRIEF	35.00	33	270	9,450	8,910
1002	-	NP OV LIMITED	50.00	50	319	15,950	15,950
1003		NP OV LOW	75.00	70	232	17,400	16,240
1004		NP OV MODERATE	110.00	100	171	18,810	17,100
1005		NP OV HIGH	123.00	120	68	8,364	8,160
1006		EST OV BRIEF	30.00	25	960	28,800	24,000
1007		EST OV LIMITED	35.00	30	1455	50,925	43,650
1008		EST OV LOW	45.00	40	823	37,035	32,920
1009		EST OV MODERATE	70.00	60	458	32,060	27,480
1010		EST OV HIGH	100.00	90	197	19,700	17,730
1011		HOSP DAY INITIAL	105.00	100	339	35,595	33,900
1012		HOSP DAY BRIEF	35.00	33	1236	43,260	40,78
1013		HOSP DAY MODERATE	50.00	50	951	47,550	47,550
1014		HOSP DAY DISCHARGE	58.00	55	335	19,430	18,42
1015		CONSULT	85.00	80	342	29,070	27,360
1016		VENT MGMT INITIAL	160.00	100	74	11,840	7,40
1017	94647	VENT MGMT SUB	100.00	60	366	36,600	21,960
		Payer total				<u>461.839</u>	409.523
Payer /	Analysis-	Medicare					
Code	CPT-4	Desc.	Charge	MC Fee	MC Vol	Gross PSR	Net PSR
1001		NP OV BRIEF	35.00	28.30	1176	41,160	33,28
1002		NP OV LIMITED	50.00	44.68	1421	71,050	63,49
1003	-	NP OV LOW	75.00	61.43	1201	90,075	73,77
1004	99204	NP OV MODERATE	110.00	91.50	816	89,760	74,66
1005	99205	NP OV HIGH	123.00	114.62	301	37,023	34,50
1006	99211	EST OV BRIEF	30.00	13.61	4865	145,950	66,21
1007		EST OV LIMITED	35.00	24.01	6877	240,695	165,11
1008	99213	EST OV LOW	45.00	33.98	3650	164,250	124,02
1009	99214	EST OV MODERATE	70.00	52.40	2137	149,590	111,97
	0004E						78,20
1010	99215	EST OV HIGH	100.00	83.11	941	94,100	
	-	HOSP DAY INITIAL	100.00	83.11 103.01	941 1598	167,790	
1010	99222		-				164,61
1010 1011	99222 99231	HOSP DAY INITIAL	105.00	103.01	1598	167,790	164,61 189,92
1010 1011 1012	99222 99231 99232	HOSP DAY INITIAL HOSP DAY BRIEF	105.00 35.00	103.01 31.85	1598 5963	167,790 208,705	164,610 189,92 215,83
1010 1011 1012 1013	99222 99231 99232 99238	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE	105.00 35.00 50.00	103.01 31.85 47.54	1598 5963 4540	167,790 208,705 227,000	164,610 189,92 215,83 89,06
1010 1011 1012 1013 1014	99222 99231 99232 99238 99252	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE HOSP DAY DISCHARGE	105.00 35.00 50.00 58.00	103.01 31.85 47.54 55.70	1598 5963 4540 1599	167,790 208,705 227,000 92,742	164,619 189,92 215,83 89,06 113,20
1010 1011 1012 1013 1014 1015	99222 99231 99232 99238 99252 94646	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE HOSP DAY DISCHARGE CONSULT	105.00 35.00 50.00 58.00 85.00	103.01 31.85 47.54 55.70 69.41	1598 5963 4540 1599 1631	167,790 208,705 227,000 92,742 138,635	164,610 189,92 215,83 89,06 113,20 30,50
1010 1011 1012 1013 1014 1015 1016	99222 99231 99232 99238 99252 94646	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE HOSP DAY DISCHARGE CONSULT VENT MGMT INITIAL	105.00 35.00 50.00 58.00 85.00 160.00	103.01 31.85 47.54 55.70 69.41 86.41	1598 5963 4540 1599 1631 353	167,790 208,705 227,000 92,742 138,635 56,480	164,619 189,92 215,83 89,06 113,20 30,50 88,47
1010 1011 1012 1013 1014 1015 1016 1017	99222 99231 99232 99238 99252 94646	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE HOSP DAY DISCHARGE CONSULT VENT MGMT INITIAL VENT MGMT SUB Payer total	105.00 35.00 50.00 58.00 85.00 160.00	103.01 31.85 47.54 55.70 69.41 86.41	1598 5963 4540 1599 1631 353 1703	167,790 208,705 227,000 92,742 138,635 56,480 170,300	164,61 189,92 215,83 89,06 113,20 30,50 88,47 1,716,86
1010 1011 1012 1013 1014 1015 1016 1017	99222 99231 99232 99238 99252 94646 94647	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE HOSP DAY DISCHARGE CONSULT VENT MGMT INITIAL VENT MGMT SUB Payer total	105.00 35.00 50.00 58.00 85.00 160.00	103.01 31.85 47.54 55.70 69.41 86.41 51.95	1598 5963 4540 1599 1631 353 1703	167,790 208,705 227,000 92,742 138,635 56,480 170,300 2.185,305	164,610 189,92 215,83 89,06 113,200 30,500 88,47 1,716,86
1010 1011 1012 1013 1014 1015 1016 1017	99222 99231 99232 99238 99252 94646 94647	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE HOSP DAY DISCHARGE CONSULT VENT MGMT INITIAL VENT MGMT SUB Payer total Analysis ss Blue Shield	105.00 35.00 50.00 58.00 85.00 160.00	103.01 31.85 47.54 55.70 69.41 86.41 51.95	1598 5963 4540 1599 1631 353 1703	167,790 208,705 227,000 92,742 138,635 56,480 170,300 2.185,305 Gross PSR	164,610 189,92 215,83 89,06 113,200 30,500 88,47 1,716,86 Net PSR 1,654,870
1010 1011 1012 1013 1014 1015 1016 1017	99222 99231 99232 99238 99252 94646 94647 ary Payer Blue Cro Medicaid	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE HOSP DAY DISCHARGE CONSULT VENT MGMT INITIAL VENT MGMT SUB Payer total Analysis ss Blue Shield	105.00 35.00 50.00 58.00 85.00 160.00	103.01 31.85 47.54 55.70 69.41 86.41 51.95 Gross Mix 33.9%	1598 5963 4540 1599 1631 353 1703 Net Mix 38.4%	167,790 208,705 227,000 92,742 138,635 56,480 170,300 2.185,305 Gross PSR 1,732,654	164,610 189,92 215,83 89,06 113,200 30,500 88,47 1,716,86 Net PSR 1,654,870 166,23
1010 1011 1012 1013 1014 1015 1016 1017	99222 99231 99232 99238 99252 94646 94647 ary Payer Blue Cro Medicaio Val-You	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE HOSP DAY DISCHARGE CONSULT VENT MGMT INITIAL VENT MGMT SUB Payer total Analysis ss Blue Shield	105.00 35.00 50.00 58.00 85.00 160.00	103.01 31.85 47.54 55.70 69.41 86.41 51.95 Gross Mix 33.9% 7.0%	1598 5963 4540 1599 1631 353 1703 Net Mix 38.4% 3.9% 2.3%	167,790 208,705 227,000 92,742 138,635 56,480 170,300 2.185,305 Gross PSR 1,732,654 355,294 108,752	164,611 189,922 215,833 89,06 113,20 30,50 88,47 1,716,86 Net PSR 1,654,87 166,23
1010 1011 1012 1013 1014 1015 1016 1017	99222 99231 99232 99238 99252 94646 94647 Blue Cro Medicaio Val-You Aetna	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE HOSP DAY DISCHARGE CONSULT VENT MGMT INITIAL VENT MGMT SUB Payer total Analysis ss Blue Shield HMO	105.00 35.00 50.00 58.00 85.00 160.00	103.01 31.85 47.54 55.70 69.41 86.41 51.95 Gross Mix 33.9% 7.0% 2.1% 5.2%	1598 5963 4540 1599 1631 353 1703 Net Mix 38.4% 3.9% 2.3% 6.1%	167,790 208,705 227,000 92,742 138,635 56,480 170,300 2.185,305 Gross PSR 1,732,654 355,294 108,752 267,510	164,611 189,922 215,833 89,06 113,20 30,50 88,47 1,716,86 Net PSR 1,654,87 166,23 100,21 261,03
1010 1011 1012 1013 1014 1015 1016 1017	99222 99231 99232 99238 99252 94646 94647 ary Payer Blue Cro Medicaio Val-You	HOSP DAY INITIAL HOSP DAY BRIEF HOSP DAY MODERATE HOSP DAY DISCHARGE CONSULT VENT MGMT INITIAL VENT MGMT SUB Payer total Analysis ss Blue Shield HMO	105.00 35.00 50.00 58.00 85.00 160.00	103.01 31.85 47.54 55.70 69.41 86.41 51.95 Gross Mix 33.9% 7.0%	1598 5963 4540 1599 1631 353 1703 Net Mix 38.4% 3.9% 2.3%	167,790 208,705 227,000 92,742 138,635 56,480 170,300 2.185,305 Gross PSR 1,732,654 355,294 108,752	164,611 189,922 215,833 89,06 113,20 30,50 88,47 1,716,86 Net PSR 1,654,87 166,23

less than market (makers have pricing options). Price takers have been paid more than market. Price takers are going to find that the only way to maintain income is by accepting more patients. After analyzing the utilization data from a variety of sources, (other historical averages or external data) it may be appropriate to notch a calculated rate up or down several percentage points to account for variability and negotiating position since HMOs invariably will want to pay less.

Deliver cost-effective care

The final step is to deliver cost effective care and to improve. The ongoing struggle to manage beneficiaries in a capitated environment is about feedback to those making care decisions. Key to this process is establishing key controls and feedback loops. The determination of necessary controls and feedback loops depends on the structure of each capitation arrangement and its associated risk pools. Ideally all decision makers want real-time information in evaluating care decisions. Invariably that is not always practical. At a minimum, for every population group for which a practice accepts capitation, there is a need to track and monitor utilization by care giver. Variations should be evaluated for possible corrective actions. Groups planning on global capitation should gather more information, such as referrals (number, to whom, for what), and admission rates.

Some time ago, a physician acquaintance lamenting the state of medicine said to me that financial people want everything too specific, where two plus two always equals four. In medicine, he explained, sometimes it's more and sometimes it's less. What this friend failed to recognize was that capitation is the introduction of those same concepts of sometimes more, sometimes less to healthcare financing. While the amount of effort any practice will need to devote to each step of this process will vary significantly depending on current practice sophistication, size of contract, and available time, it does provide a framework in which to make decisions in these rapidly changing times. Physicians stand to benefit during this evolution.

The author is chief of MSO Development for the Michigan State Medical Society

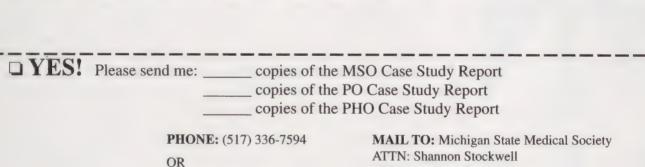
Sample spreadsheet from a revenue analysis of an imaginary internal medicine group practice.

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Project Consultant: Thomas M. Gorey, JD

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Physician Activism

You can help Stop America's Violence Everywhere

By Janet Gregory

Physicians are one group of people who don't need to be reminded of the devastating effect of violence on our families, our health care system, and our society. That's why you are invited to help the county, state, and national medical society alliances SAVE Today...Stop America's Violence Everywhere. Governor Engler will sign a proclamation declaring October 9, 1996 as SAVE Today, a national day to Stop America's Violence Everywhere.

statistics violence in this country are frightening. Firearmrelated injuries are second only to motor vehicle injuries as a cause of death among people 10-34 years of age; more than 500,000 emergency room visits every year are due to violent injury; medical expenses from domestic violence total more than \$5 billion annually. recent bombing at the Olympic Centennial Park and the mysterious crash of TWA Flight 800 brought

The MSMS Alliance encourages Michigan physicians to get involved in SAVE Today by ordering SAVE stickers and posters for distribution in offices to let patients know that they can have a role in solving local problems related to violence. The public will be encouraged to take part

the issue of terrorism home

to America.

in SAVE Today by displaying SAVE stickers on their car bumpers and windows; making their neighborhoods "SAVE zones"; turning off violent media programming for the day; or helping a nearby shelter for victims of abuse.

With SAVE Today as its centerpiece, the year-round SAVE Program is a national effort of more than 60,000 physicians' spouses to combat

violence and provide support to its victims.

Launched in June 1995 by the AMA Alliance House of Delegates, the SAVE Program represents the continuation of a six-year commitment that began when the organization joined the AMA's Campaign Against Family Violence. More than 800 state and county alliances will observe SAVE Today, involving millions of local citizens, community organizations, and physicians throughout the country.

To receive SAVE stickers for your patients, to order a poster for your waiting room, or for additional information on how you can be involved in SAVE Today, contact Jennifer Anibal, MSMS Alliance Executive Director at 517/336-7595 or by e-mail at janibal@msms.org

Every effort, no matter how large or small, is one step closer to "stopping America's violence everywhere." Please join us.



Mrs. Gregory is MSMS Alliance president for 1996-97.

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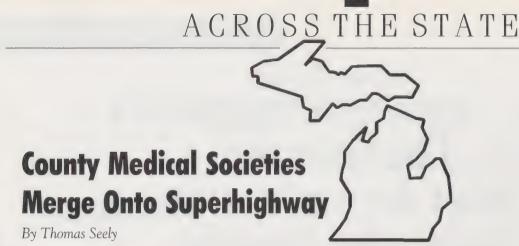
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he world today is gaining ac cess to the Internet and World Wide Web. Businesses as well as private persons are getting home pages up and running. Even the medical profession is becoming more and more involved in the superhighway of information. Doctors are beginning to see continuing medical education on-line. The American Medical Association (http://www.ama-assn.org/), the Michigan State Medical Society (http://www.msms.org), and various specialty societies have home pages.

And now county medical societies are starting to show up on the Internet.

Kalamazoo first

On May 14, 1996, the Kalamazoo Academy of Medicine (KAM) was the first county medical society in Michigan and one of only a few in the nation to get its home page up on the Internet.

"Members who have seen our home page are very impressed and excited about the future of this project," said Susan Saewert, executive director of the Kalamazoo Academy of Medicine. The Academy has on its page a calendar of events, KAM bulletin editorials, a membership application, KAM Alliance information, and more. Its Internet address is http://www.msms.org/kam.htm.

"We are working on new information to include on our page that will benefit our members and the community," said Donald H. Batts, MD, president of the KAM. For example, a physician finder will be available for people looking for particular specialists. The patients will be asked to describe their symptoms and indicate the area of the county in which they would like to see a physician, and the type of insurance they carry. They then will be provided a list of physicians meeting their criteria.

"Eventually, physicians will have individual links with our home page to their own home pages," he said. Also, member physicians will be able to post information about conditions in terms the public can understand. The pages will contain symptoms to look for, treatments and recommendations.

Another goal for the KAM Home Page is to list up-to-date medical information for children to access. "If a child is doing a book report for a science class and needs a resource other than the encyclopedia, they can link up to our home page," said Doctor Batts. This information will be written so that children can easily understand it.

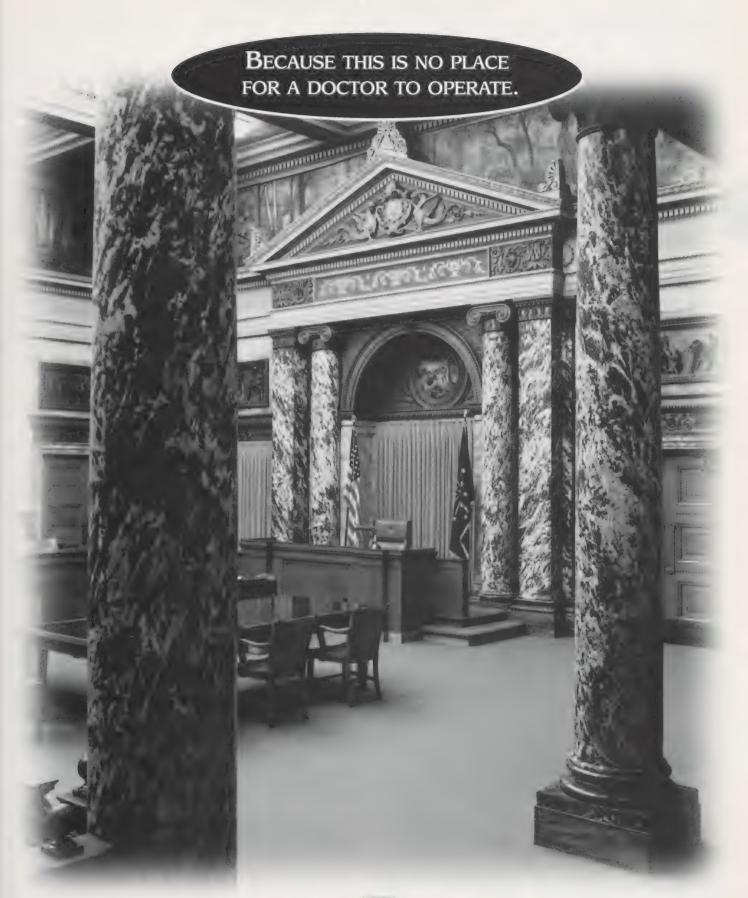
Kent County on-line

The Kent County Medical Society also has a home page. The address is http://www.kcms.org. Some of the information available on its page includes legislative updates, Kent Medical Foundation, KCMS Alliance, and general KCMS and membership information.

If you would like more information about establishing a home page on the Internet or about MSMSNET, please contact William DeCourcy at MSMS at (517) 336-7575 or e-mail him at wdecourcy@msms.org.

What is happening in your neck of the woods?

Michigan Medicine would like to develop and expand this monthly feature to include news from various sources across the state. That includes county medical societies, specialty medical societies, physician organizations, business coalitions and other organized groups involving physicians. Send your news by mail, fax, e-mail or phone to Tom Seely, chief of physician outreach programs, P.O. Box 950, East Lansing, MI 48826-0950; fax (517) 337-3490; e-mail tseely@msms. org; or phone (517) 336-5770. Photos in either black and white or color are accepted and will be run on a space available basis.



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MICHIGAN STATE MEDICAL SOCIETY

University of Michigan Medical Center

June 28, 1996

Dear Colleague:

Recently representatives from the Michigan State Medical Society (MSMS), the International Medical Graduate (IMG) Section of MSMS, and the University of Michigan Medical Center met to discuss issues related to graduate medical education. This very productive session resulted in the following outcomes:

- All parties affirmed the principle that the selection of educational trainees should be based on merit without reference to medical school origin or other bases.
- The group reviewed and agreed with the University's "Principles of Graduate Medical Education."
- 3) The parties affirmed a shared vision for the continued education of physicians throughout the State of Michigan, and expressed concern for the future of funding for medical education, both at the resident and the medical student level.
- 4) The parties agreed that the sharing of ideas and views at this meeting was extremely useful to all, and recommended that the IMG leadership meet with medical school leadership at least once a year.
- 5) The University's commitments to quality education programs and diversity were affirmed. The University will maintain its commitment to diversity. The University's commitment to educational opportunities for international medical graduates is reflected in the growth of the numbers of IMGs serving in UM residency programs from 49 in 1990, to 60 in 1991, to 56 in 1992 to 77 in 1993, to 83 in 1994, to 86 in 1995.

We look forward to a close and productive working relationship towards shared goals at the state and national level.

For the Michigan State Medical Society:

V. Peter McCabe, M.D.

Kenneth A. Jordan, M.D.

Kenneth A. Jordan, M.D. / Chair, International Medidal Graduate Section

Krishna K. Sawhney, M.D.
Chair, MSMS Board of Directors

For the University of Michigan Medical Center:

Gifes G. Bole, M.D. Dean, UM Medical School

John E. Billi, M.D. Associate Dean for Clinical Affairs UM Medical School

James O. Woolliscroft, M.D. Chief of Clinical Affairs UM Hospitals

hat's the outcome of recent discussions between the Michigan State Medical Society and the University of Michigan Medical Center. MSMS initiated those discussions when concerns arose about selection procedures. Printed here is the resulting agreement regarding graduate medical education principles. The agreement does not discriminate against IMGs, regardless of school of training, but rather, reaffirms that the selection of educational trainees should be based on the quality of the applicants.

This agreement is a reflection of the Michigan State Medical Society's longstanding commitment to international medical graduates in our state: MSMS was the first state medical society to form an International Medical Graduates Section, and MSMS is pushing for the creation of a nationwide IMG section within the AMA.

More than 2,700 international medical graduates are members of MSMS.

"This is a good process," said AppaRao Mukkamala, MD, Chair, AMA IMG Caucus, and former chair of the MSMS IMG Section. "We appreciate MSMS's role in the resolution of this situation."

SOCIETY NEWS

MSMS agrees with the following U-M principles

Graduate Medical Education Principles

The University of Michigan Medical Center has a distinguished record of excellence in graduate medical education. We are committed to maintain this record of excellence despite possible reductions in funding and other mandated changes in the future. Insofar as possible, we will conduct our GME program management consistent with the following principles.

1. Institutional (CDS) approval is required for any alteration in the institutionally funded numbers of house staff or in

the required length of a training program.

• The number of house staff may not exceed the number approved by the RRC.

- 2. The institution (CDS) is committed to provide a quality educational experience and to secure funding for all house officers accepted into our GME programs to the completion of their training as required by the individual Boards (including ABMS-approved subspecialty training).
- 3. Programs are expected to seek out and appoint high quality house staff who qualify for HCFA funding and other reimbursement. Individuals

who do not meet these criteria will be appointed only after institutional peer review and approval.

- 4.UM house officer's stipends, fringe benefits and malpractice insurance costs will be paid by the institution (or agency) at which they are assigned for their educational experiences. Any exception must have institutional approval.
- 5. Special Purpose Trainee (SPT) assignments will be funded by the CDS only when the arrangement has been institutionally approved.

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NEWSMAKERS

Alfred B. Swanson, MD, a pioneer in surgical treatment of the



arthritic hand, upper extremity and forefoot, is the recipient of the 1996 American Medical Association's Scientific Achi-

evement Award. During his 40 years as Director of Orthopaedic Surgery for Grand Rapids hospitals, Doctor Swanson has guided numerous students, many who are now head of departments in their own country, through one of the top residency programs. His passion for educating others about medicine triggered Doctor Swanson to coordinate a Hand Training Program for South Vietnamese students, a development for which he received the Medal of Honor from the South Vietnamese government.

Gregory L. Henry, MD, FACEP, chief of the Emergency Department at Oakwood Hospital Beyer Center in Ypsilanti, recently shared viewpoints regarding defense matters with students of the US Army War College at a weeklong National Security seminar. The Ann Arbor doctor and nearly 140 other leaders from business, government, media and academia exchanged civilian viewpoints about defense matters with up-andcoming military leaders during the five-day annual seminar at the Carlisle Barracks in Pennsylvania.

Wayne State University biomedical researcher, Kenneth Maiese, MD, received the Johnson & Johnson Focused Giving Award for his innovative research in neurodegenerative disease therapy. Doctor Maiese, a Birmingham resident whose work may diminish the debilitating effects of strokes, leads a research team in the exploration of cellular and molecular mechanisms that lead to neuronal cell death. He also serves as an associate professor of neurology and molecular medicine/genetics at Wayne State University. The \$225,000 award he received is given by I & I to fund scientists' basic research.

Peter A. Ward, MD, of Ann Arbor, is the new president of the American Board of Pathology.

Doctor Ward, a Godfrey D. Stobbe Professor, is also the chair of the Department of Pathology at the University of



Michigan Hospital.

Family practice educator, Archie W. Bedell, MD, PhD, Ottawa Lake, is the new president of the Michigan Academy of Family Physicians. Doctor Bedell is the Medical Director of the Family Practice Residency Training Program and Director of Medical Education for Mercy/St. Charles Hospitals in Toledo, Ohio. He plans to focus his presidency on educational excellence in family practice, increasing managed care opportunities for family practice colleagues and encouraging more cohesive relationships between physicians of all specialties and organizations.

Kalamazoo's first certified practicing pediatrician, H. Sidney Heersma, MD, has been named the recipient of the 1996 E. Earl Wright Community Achievement Award. At 87 years old, Doctor Heersma continues to aid those he has been helping since 1937: severely mentally and physically handicapped children and children with neurological and behavior disorders as well as their families. W.E. Upjohn Institute and the Greater Kalamazoo United Way chose Doctor Heersma, a practitioner at the Major Disease Clinic at the Michigan State University Kalamazoo Center for Medical Studies, for leadership and service he has given Kalamazoo County.

Vice Chair of the Henry Ford Medical Group, William A. Conway, Jr., MD, Detroit, has been elected treasurer of the American Medical Group Association. Doctor Conway operates an active clinical practice in pulmonary and critical care medicine.

(continued on page 42)

Michigan State Medical Society Presents Exciting Tours From Detroit







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Deaths

MSMS member Ghassan Haurani, MD, Grosse Pointe Shores, died July 14 with his wife, Nina, in the crash of TWA Flight 800 off East Moriches, Long Island, NY.

Doctor Haurani was a vascular surgeon at St. Joseph's Mercy Hospital since 1977. A Syrian native, he graduated from French University Medical School in Beirut, Lebanon. He was president-elect of the Oakland County Medical Society and chair of the August 17, 1996 Docs/locks run to combat domestic violence.

Former Director of Surgical Residency Education Program at Henry Ford Hospital, Angelos A. Kambouris, MD, Southfield, died June 28 at the age of 66. Doctor Kambouris held professorships at Wayne State University and University of Michigan Medical School. A Greek native who graduated from the National University of Athens Medical School, Doctor Kambouris was also the Chief of the Division of General Surgery at Henry Ford Hospital.

Samuel S. Bernstein, MD, Southfield, died January 12 at the age of 89. Doctor Bernstein was a pediatrician who once served as the Detroit Pediatric Society president and as an associate professor of pediatrics at Wayne State University School of Medicine. A veteran who graduated from the University of Chicago Medical School, he entered World War II as a captain in 1942 and was discharged in 1946

having attained the rank of lieutenant colonel. Doctor Bernstein was also a member of the American Academy of Pediatrics and the Pediatric Research Society.

Walter A. Meier, MD, Adrian, a program physician for the Salvation Army Harbor Light, died May 31 at the age of 77. Doctor Meier, a University of Michigan Medical School graduate, was the Monroe County Health Director and an emergency room physician at Mercy Hospital Unit before resuming his private practice in 1980. He served as the Monroe County Medical Society president, trustee for the Michigan Cancer Foundation, a member of the Governor's Committee on Migrant Labor and as past president of the Michigan Lung Association among numerous others.

Bohumil A. Samal, MD, an oncologist at Hutzel Hospital, Detroit, died June 6. He was 62. Doctor Samal, a Czechoslovakian native, served as a physician at Harper-Grace and Hutzel Hospitals. He was also an associate professor of medicine at Wayne State University and a member of the Amercian Society of Clinical Oncology and the American College of Physicians.

Otolaryngologist, Joseph L. Sanderson, MD, Port Huron, died June 7 at the age of 89. Doctor Sanderson, the fourth generation of his family to practice medicine, began his career as a physician in Detroit, then moved to Port Huron where he practiced for 41 years before retiring in 1987.

Gordon D. Daugharty, MD, a St. Clair obstetrician and gynecologist, died January 1 at the age of 61. Doctor Daugharty attended McGill University in Quebec, Canada and was a member of the American College of Obstetricians & Gynecologists, the American Fertility Society, the Ethics Committee for the St. Clair County Medical Society and a physician at River District Hospital, St. Clair. He was a graduate of the University of Michigan Medical School.

New Members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Muhyi Al-Sarraf, MD, Southfield

W. J. Bartlett, MD, Saginaw

Carl T. Bergren, MD, Dearborn

Ziad Berri, MD, Dearborn

Peter Bistolarides, MD, Ann Arbor

Seth N. Blumberg, MD, Farmington

Michael P. Buetow, MD, East Lansing

Victor I. Corondan, MD, Centerline

David J. Diehl, MD, Saline

Lisa A. Fulgenzi, MD, Royal Oak

PEOPLE

Juan M. Gonzalez Bernal, MD. Jackson

John Gonzalez-Clanton, MD, Harbor Beach

Kenneth Grimm, DO, Jackson

Lisa L. Guyot, MD, Lincoln Park

Donna Hoban, MD, Grosse Pointe Farms

Diane G. Holland, MD, Ann Arbor

Khawaja H. Ikram, DO, Jackson

David R. Johnson, MD, Lansing

Jane E. Krasnick, MD, Eastpointe

Mohan Kulkarni, MD, Jackson

Sajid Latif, MD, Detroit

Frederick Lawrence, MD,

Roscommon

Yi-Shiuan J. Lee, MD, East Lansing

Zvi Levran, MD, Livonia

Fred Lueder, MD, Dearborn

Nadia Mazraani, MD, Canton

Matthew M. McCord, MD, Ann Arbor

Scott C. McDougall, DO, Reese

Ali Moiin, MD, Detroit

Laura L. Morris, MD, East Lansing

Lisa M. Mulligan, MD, Ypsilanti

Edward T. Murphy, MD, Grand Rapids

Bruce Newman, MD, Detroit

Jeffrey D. Recknagel, MD, Muskegon

Gary M. Ritten, MD, Bad Axe

Robert A. Rooney, MD, Bloomfield

Jacquelyn A. Ryan, MD, Clawson

Wael Salman, MD, Owosso

Perminder S. Sanghera, MD, Harbor Beach

Miriam T. Schteingart, MD, Saginaw

Shishir H. Shah, MD, Detroit

Akash R. Sheth, MD, Grosse Pointe Woods

Tari S. Stull, MD, Tecumseh

Bobbie C. Sutton, MD, Lansing

John E. VanSchagen, MD, Grand Rapids

William P. Walker, MD, Kalamazoo

Bonita M. Wang, DO, St. Clair Shores

Joel L. Young, MD, Rochester Hills

Carl J. Zylak, MD, Detroit

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Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: George M. Bridgeforth, MD, 5100 South Ellis, Chicago, IL 60615

Action, Date Taken: Reprimand, Fine \$1,000.00, 8-16-96

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: James C. Danforth, Jr., MD, 10 Willow Tree Place, Grosse Pointe Shore, MI 48236

Action, Date Taken: Permanent Surrender of License Reason: Failure to Meet Continuing Education Requirements

Name: Kenneth W. Frye, DO, 2480 84th Street, Byron Center, MI, 49315

Action, Date Taken: Permanent Surrender of Controlled Substance and Drug Control Licenses, 8-16-96 **Reason:** Controlled Substance Violations

Name: Keithley E. E. Johnson, MD, Box 452, Detroit, MI 48231

Action, Date Taken: (Correction) License Revoked, Summary Suspension Dissolved, Fine \$50,000.00, 08-

Reason: Criminal Conviction - Drug Related

Name: Lawrence J. Kitterman, MD, 2370 S. State, Davison, MI 48423

Action, Date Taken: License Suspended - 6 months and 1 day, 7-17-96

Reason: Substance Abuse

Name: Dan F. Kreuzer, DO, 2946 146th Avenue, SW, Byron Center, MI 49315

Action, Date Taken: Reclassified w/Unlimited License, 07-01-96:

Name: Avni D. Ozkan, MD, 1444 Michigan NE, Suite F, Grand Rapids, MI 49503

Action, Date Taken: Probation - 2 years and Fine -\$1,000.00, 7-12-96

Reason: Negligence

Name: Michael J. Schnitzer, MD, Box 1767, Sausalito, CA 94966

Action, Date Taken: Permanent Surrender of Controlled Substance License, 8-16-96

Name: Francis A. Swan, MD, 23820 N. 1900th Road, Bushnell, IL 61422

Action, Date Taken: Licensure Denied, 07-16-96

Reason: Substance Abuse

Name: Clarence W. Wilson, DO, RPh, 3415 Santa Clara, Flint, MI 48501

Action, Date Taken: Summary suspension dissolved, Pharmacist & Controlled Substance Licenses Revoked and Fine - \$1,000.00

Reason: Criminal Conviction - Drug Related

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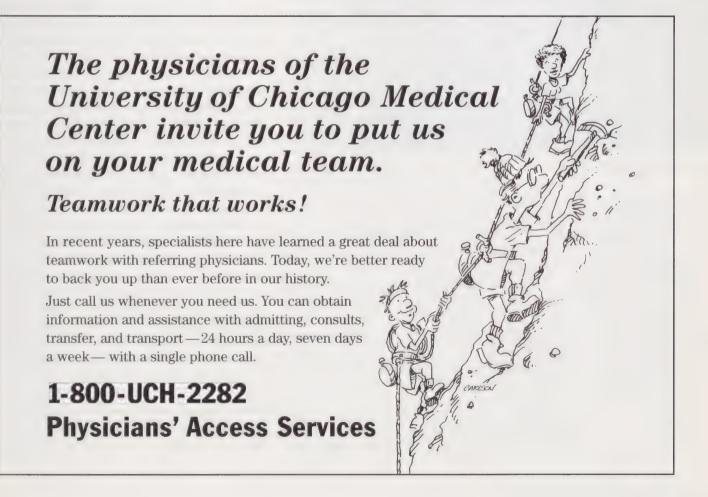
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Challenging the Clock

Doctor's research may help prevent aging

By Ralph D. Ward

he biological markers of human aging are well known in the medical world, a checklist of decline that makes it possible to pinpoint a patient's approximate age with close accuracy.

Despite an accelerating pace of medical advance, at least in the western countries, the increase in average human life span has slowed over the past decade or two. On average people in the U.S. live to be around 75. That can be nudged upward toward 80, but what then? We still face a biological clock, ticking inexorably. Also, we see diminishing returns on stretching out our life span, which leaves us with new concerns of if (or when) to withhold treatment for growing numbers of the aged infirm. How can we cope with such a paradigm?

By smashing the current paradigm, and moving on to the next level, according to Michael B. Fossel, MD, PhD, Ada. Doctor Fossel, a professor of clinical medicine at Michigan State University, has published a new book on just how such a revolution may take place. Reversing Human Aging, published by William Morrow earlier this year, examines how genetic research has taken us to the threshold of radically longer, and radically healthier, lives.

"Aging has been an interest of mine for 20 years," says Doctor Fossel, but he admits to sharing in the long-term frustration among researchers in that field.

Various body chemicals, such as DHEA and melatonin, are found to decline with age and their potential as a "fountain of youth" is suspected, until further research finds their effects ambiguous at best. "We couldn't get anywhere with [aging]," recalls Doctor Fossel. Three years ago he attended a conference on the biochemistry of aging, "a sort of dull affair, with boring lectures," and found little that was new. But on the last day of the conference, he sat in on a seminar by Dr. Calvin Harley of McMasters

University, on the role of telomeres in aging. "I was impressed... this tied up a lot of loose ends on aging."

Telomeres role in aging

What are telomeres? Telomeres are "the clocks of aging," according to Doctor Fossel's book. They are the tag end of DNA sequences on our chromosomes. As telomere sequences die out with age, their shortening slowly closes down the body's ability to reproduce cells, to repair damage, and properly control replication. The human factory slowly goes into collapse, allowing the entropy of age, decline and illness to take over.

Doctor Fossel's subsequent discussions with Doctor Harley and other researchers filled in further gaps in a comprehensive model of aging. One of Doctor Fossel's interests had been the medical syndrome known as progeria. Progeria consists of several diseases of rapid aging whose effects range from killing victims a decade or two before their time, to the extreme of children in their teens literally dying from the symptoms of old age. These subjects obviously do not "wear out" from age, so some damage at the cellular level is occurring to speed up the body's clock. That damage has proven to be shortened telomeres.

Other medical research likewise turned up clues on the crucial role of telomeres. Their decline not only hobbles the ability of cells to repair themselves, but also weakens control of the growth that does occur. There is a term for cells that are allowed to keep reproducing without limit — cancer. While research on the use of telomere gene therapy for aging is only beginning, "telomerase inhibitors" are already being used to switch off cancerous cells. Doctor Fossel predicts that this use for gene therapy will offer the fastest payoff, and that we may be able to clinically cure most cancers within a decade. The "shortening" of our telomeres will be found

"Aging has been an interest of mine for 20 years" says Doctor Fossel. but he admits to sharing in the long-term frustration among researchers in that field.

at the heart of many other diseases associated with aging, according to Doctor Fossel, including arthritis, Alzheimers, stroke and heart disease. These illnesses will in turn yield to telomere gene therapy, likely within 15 years.

Doctor Fossel hastens to note that no one is going to live forever, even with tidied-up The death of brain cells, telomeres. environmental factors, infections, bodily wear and tear and accidents will prove the next, and likely ultimate, barriers to immortality. Indeed, new health concerns will crop up. Exposure to environmental factors, such as sunlight, chemicals and even vitamins that are minor or even beneficial over a current lifetime could prove harmful if that life span is doubled.

Clinical possibilities

So with the telomere damage reparable, what would be the effect on human life span? Doctor Fossel has extrapolated current age and life span curves to factor out the effects of aging and telomere-related disease, and finds the results mind boggling. "Your life span can be extended by several hundred years," he writes in Reversing Human Aging. Living to be 200, 250, even 300 will not be unusual.

Along with his MD, Doctor Fossel's PhD studies allow him some deeper insights on the radical change life spans of several hundred years would bring to western society. Consider current retirement policies. Nudging the retirement age upward toward 70 from 65 has gone on for several decades.

Now what happens when people live to be 250? Employment. Health care.

Economics. Demographics. Reproduction. Careers. Social roles. The number, and enormity, of unanswered questions is almost enough to put us off the idea of telomere tinkering.

Since publication in April, Doctor Fossel's book has enjoyed strong sales. "Sales are going very well for a first book." Public notice has likewise been intense, with national media



Doctor Fossel from the jacket of his new book.

coverage on Good Morning America and CNN, as well as overseas coverage with the BBC and Der Spiegel magazine.

For the future, this Michigan physician is planning a sequel to his book, examining the specific possibilities of telomere therapy for cancer treatment. "The potential is enormous,"

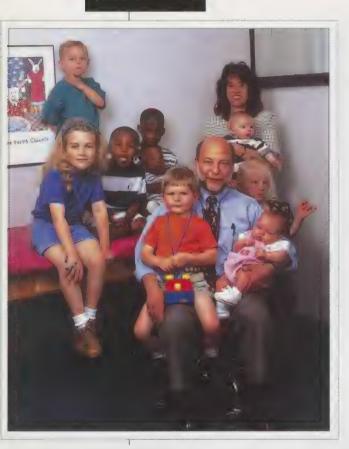
If Doctor Fossel's predictions prove correct, he should have plenty of time to write many more sequels.

The author is a Riverdale, Michigan-based freelance writer.

"Your life span can be extended by several hundred years"

Protecting Michigan's children

Peer education project targets Michigan's immunization rates



he Peer Education Project on Immunizations, administered through a Michigan Department of Community Health grant, educates health professionals and raises public awareness of the need to fully immunize Michigan's youngest citizens. The project began last spring after the Centers for Disease Control announced Michigan was last of all the states in immunizing children two years old and younger. The project has worked closely with Nancy Fasano, Chief of the MDCH Immunization Section, David K. Johnson, Medical Director for MDCH; and James Haveman, Jr., Director of MDCH. Other key groups involved include the Alliance for Immunization in Michigan (AIM), osteobathic physicians, nurses, and other health professionals, MSMS is striving to better Michigan's rates.

Howard Weinblatt, MD, Ann Arbor pediatrician, is chair of the MSMS Task Force on Immunizations, advisory group to the Project, and member of AIM. Surrounded by kids in his practice, and his administrative assistant, Deb Wages, he calls on his colleagues to update their immunization practices.



Physician Training Schedules

Immunization training programs for healthcare providers will take place Wednesday, October 2, from 8:00 a.m. to 12:00 noon, at Michigan Association of Osteopathic Physicians and Surgeons' Southfield location; and that afternoon from 1:00 p.m. to 5:00 p.m., at the Wayne County Medical Society in Detroit.

Physicians and nurses debunk immunization myths and learn of the latest vaccines at one of several training sessions scheduled by the Project. This one was at MSMS headquarters. Each participant receives an extensive packet of materials, including overheads, to equip them to make further presentations to their colleagues. The CDC is using the Michigan packet as a model for similar campaigns across the country.



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We encourage individual practices, hospital department meetings and county medical societies to further educate themselves on vaccines.

Please Call Kathy Holcomb, Coordinator at 517-336-5707 or e-mail to kholcomb@msms.org or Jean Capriotti at 517-336-5706 or e-mail to jcapriotti@msms.org.

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EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

October

1, 8, 15, Bar-Levay Education Association Ongoing Seminar Series "The therapist's character and its impact on the patient." Location: Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

4-5, "Advances In Cognitive Therapy: Focus on the Interpersonal Process." Presented by Bruce S. Liese, PhD, ABPP. Location: Conference Center, Menninger Clinic, Topeka, KS. Sponsor: The Menninger Clinic Contact: Menninger Continuing Education 800-288-7377, or, (913) 350-5992 Approved for: 11 hours of Category 1 credit Fee: \$220

7-8, Second Annual Cardiology for the Consulting Cardiologist: Balancing Intervention with Enlightened Medical Therapy. Location: Four Seasons Hotel, Boston, MA. Sponsor: American College of Cardiology. Contact: EP, American College of Cardiology, PO Box 79231, Baltimore, MD 21279-0231 (800-253-4636, ext 695). Approved for: 12 Category 1 credit hours. Fees: \$445 members, \$505 non-members, \$325 fellows-intraining, residents, nurses, PAs, technologists. Fees higher after Sept. 20.

10-12, "Cardiology Update 1996." Location: Carmel Valley Ranch Resort, Carmel, CA. Sponsor: American College of Cardiology. Contact: EP, American College of Cardiology, PO Box 79231, Baltimore, MD 21279-0231 (800-253-4636, ext 695). Approved for: 12 hours Category 1 credit. Fees: \$480 members, \$555 non-members. Fees higher after Sept. 26.

10-12, "13th Annual Santa Fe Colloquium on Cardiovascular Therapy: Therapy of Acute and Chronic Myocardial Ischemia" Location: Eldorado Hotel, Santa Fe, NM. Sponsor: American College of Cardiology. Contact: EP, American College of Cardiology, PO Box 79231, Baltimore, MD 21279-0231 (800-253-4636, ext 695). Approved for: 16 hours Category 1 credit. Fees: \$400 members, \$475 non-members, \$245 fellows-in-training, residents, nurses, Pas, technologists. Fees higher after Sept. 26.

12-16, "Board Review Course in Cardiac Electrophysiology." Location: Hyatt Regency Hotel, Chicago, IL. Sponsor: North American Society of Pacing & Electrophysiology and the American College of Cardiology. Contact: NASPE, (508) 647-0100, FAX: (508) 647-0124. Approved for: Maximum of 33 hours of Category 1 credit. Fee: \$800 NASPE/ACC Members; \$900 Non-members.

11-12 "Essentials of Prostate and GUI Imaging." Location: La Mansion Hotel, San Antonio, TX. Sponsor: Foundation for Medical Education and the Medical Education Collaborative. Contact: Foundation for Health Education, 800-599-8878, or, (908) 636-1256 Approved for: 13 hours of Category 1 credit Fee: \$565 physicians; \$450 residents, sonographers, nurses, technologists.

14-16, 1996 International Meeting on ANCA and ANCA-Related Diseases, The 7th International ANCA Workshop. Location: Phillips Hall, Siebens Building, Mayo Clinic, Rochester, Minnesota. Sponsor: Mayo Foundation. Contact: Postgraduate Courses, Section of International Medical Education, Mayo Foundation, Rochester, MN 800-323-2688 or (507) 284-8399; Fax (507) 284-0532

22, 29, Bar-Levav Education Association Ongoing Seminar Series "When is a change of psychotherapists clinically indicated." Location: Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

24-26, "New Techniques and Concepts in Cardiology." Location: Hyatt Regency Capitol Hill, Washington, DC. Sponsor: American College of Cardiology. Contact: EP, American College of Cardiology, PO Box 79231, Baltimore, MD 21279-0231 800-253-4636, ext 695. Approved for: 16 hours

EDUCATIONAL OPPORTUNITIES

Category 1 credit. Fees: \$460 members, \$535 non-members, \$325 fellows-in-training, residents, nurses, PAs, technologists. Fees higher after Oct. 10.

25, "22nd Annual Endocrinology & Metabolism Update." Location: Marriott at University Place, East Lansing. Sponsor: Michigan Capital Healthcare, CME Department. Contact: Michigan Capital Healthcare - CME Department (517) 334-2107. Approved for: 6.5 hours of Category 1 credit.

25-26, "Practical Vascular Concepts." Location: Buena Vista Palace, Orlando, FL. Sponsor: Foundation for Health Education and the Medical Education Collaborative. Contact: Foundation for Health Education, 800-599-8878, or (908) 535-1256. Approved for: 13 hours of Category 1 credit. Fee: \$565 physicians; \$450 residents, sonographers, nurses, technologists.

25-27, Advances in Sonography; Fifth Annual Meeting and Postgraduate Educational Course. Location: The Fairmount Hotel, San Francisco, CA. Sponsor: Society of Radiologists in Utlrasound. Contact: SRU office, 1101 Market Street, 14th Floor, Philadelphia, PA 19107, (215) 574-3183; Fax (215) 923-1737; E-mail sru@acr.org.

26, "Current Therapies in Otolaryngology." Location: Judd Auditorium, Mayo Building, Mayo Foundation, Rochester, MN. Sponsor: Mayo Foundation. Contact: Registrars, Mayo Foundation, Sec-

tion for CME, 800-323-2688, FAX: (507) 284-0532. **Approved for:** 5 hours of Category 1 credit **Fee:** \$95.

27-31, 48th Annual State-of-the-Art Conference. Presented by the American College of Occupational and Environmental Medicine. This year's theme is "Managed Care & Occupational Medicine: The Next Generation." The conference will feature 16 postgraduate seminars, 8 concurrent scientific sessions and 22 informal seminar groups. Location: Sheraton Centre Toronto Hotel & Towers, Toronto, Canada. Contact: ACOEM, 55 W. Seegers Rd., Arlington Heights, IL 60005, phone: (847) 228-6850, fax: (847) 228-1856. **Approved for:**

28-30, Clinical Reviews 1996. Location: Mayo Civic Center, Rochester, Minnesota. Contact: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First St. S.W., Rochester, MN 55905. Phone 1-800-323-2688; Fax (507) 284-0532 Approved for: 20 Category 1 AMA.

November

5, 12, Bar-Levav Education Association Ongoing Seminar Series "The future of psychotherapy." Location: Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. Contact: Lester Potempa, DO at (810) 353-5333. Approved for: 4 hours Category 1 Credit. No registration fee.

13, "Moans and Groans: Health Care for the Athletic Family." Location: Sinai's Zuckerman Auditorium, Detroit. Sponsor: Sinai Health System's Department of Family Practice. Contact: (313) 493-5050. Approved for: 8 hours of AMA Category 1 credit.

14-16, "1996 MSMS Annual Scientific Meeting." Sponsor: Michigan State Medical Society Location: Lansing Center, Lansing, MI. Contact: Patty Bokovoy at MSMS at (517) 336-5729 to register. Fees: \$25.00 Registration Fee (includes lunch). Per Session Fee: \$65 members; \$35 resident & retired members; \$65 nurses; \$85 non-members. (Students - no charge except for \$15.00 for lunches.) Approved for: 17 hours Category 1 credit.

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- Surgical Approaches to Liver Transplants
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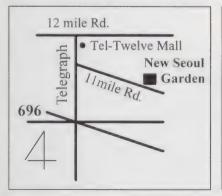


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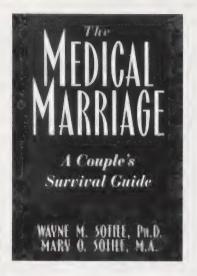
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Ask Our Lawver

(continued from page 8)

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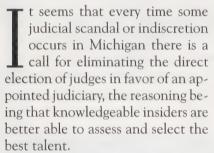
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PRESIDENT'S PERSPECTIVE

Working with the System

Judicial elections serve the public well

By W. Peter McCabe, MD



This reasoning not only betrays an unflattering lack of faith in the body politic, it also attributes more discriminating judgment to the power crowd than is usually deserved. Back in New England where I grew up, judicial elections are unheard of. Judges are all appointed, usually after some cursory review by the local bar association. As a result, every hack legislator retiring from politics gets a judgeship. The effect on the bench is predictable. In my home state of Rhode Island, the last two Chief Justices of the Supreme Court have ended up in the pokey, one a former Speaker of the House who did lucrative business with the mob; and his successor another former legislator who got caught with his hand in the cookie jar.

Here in Michigan where judges are for the most part elected, the situation isn't quite as tight and cozy. Theoretically the people can exercise a level of restraint and control over the excesses which can occur on either extreme of the philosophical spectrum. The problem is that voters rarely educate themselves on the vagaries of judicial performance, to the point where incumbency, a war chest collected from lawyers, and certain Irish names are almost certain tickets to election.

Notwithstanding these pitfalls, however, the popular election of judges does offer the citizenry an opportunity to assure that conduct and philosophy reflect that of the community. This is no more apparent that in the performance of our own Michigan Supreme Court, and it is glaringly apparent when one considers that the fate of the medical liability tort reform bill that MSMS fought for so laboriously over the years hangs on the majority vote of the seven mere mortals who make up the Court.

For years, many of us have lamented the increasing prevalence of a new breed of activist judges who come to the bench with their own agendas, not content with the traditional role of interpreting the law, but intent on making law as well, in effect usurping the role of the Legislature. It is not only the prerogative but the duty of citizens to rein in the more extreme legal



views of such judges.

MSMS has directed efforts toward this very end, helping organize the Alliance for Judicial Accountability (AJA), a coalition of interested parties which seeks, among other things, to counterbalance the significant influence lawyers have in raising money to support judicial candidates who are likely to rule in favor of their own vested interests.

Judges can exert enormous influence over the fate of individuals as well. MSMS is struggling with the case of a member who was slapped with a default judgment for \$700,000 even though the process server admitted in court he never served the doctor. The Wayne County Circuit judge involved has repeatedly refused to vacate the judgment and give the defendant his day in court. Meanwhile collection efforts are proceeding, threatening to bankrupt the physician.

It is this kind of judicial bullying and suspect behavior which the AJA seeks to minimize. It deserves all our support. ■

Doctor McCabe is MSMS president.

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MichiganMedicine

COVER STORY



AN ELECTION YEAR SPECIAL:

Your Vote Needed Nov. 5! 14

The fate of your 1993 medical liability reforms rests on the shoulders of this year's Michigan Supreme Court candidates. How will you vote, Doctor? This month's cover story helps prepare you to make the right choices in that crucial election. It also profiles the top 10 "hot" legislative races for support of medicine in Michigan. Also included: the names of every Michigan candidate endorsed by the Michigan Doctors Political Action Committee. And, you will be challenged with the stories of your most politically informed and active colleagues. Want to join in this exciting and needed volunteer work? See the MDPAC membership form. It's your turn.

Cover photo by: Roger Hill

Six Physicians Who Serve

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These physicians have taken a personal interest in seeing to it that legislators hear physicians' concerns. By Karen Bouffard

Top 10 State Races

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Among those seeking election, physicians should watch these 10 candidates, as their tight challenges could prove key to physicians' concerns.

A "How-to" Guide for Campaign Volunteering

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Volunteering for a political campaign could involve writing letters to colleagues and a chance to seat your candidate in the legislature.

By Donna Welch LaGosh

PACs Meet Public Interest Needs

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Individual, average Americans comprise today's PACs to support common interests.

MDPAC's Endorsed Candidates

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The complete list, by legislative district, of every Michigan candidate for office, endorsed by the Michigan

On the cover: MSMS members in a variety of politically active roles. Clockwise from upper left — MSMS officers approach the Michigan Capitol early this year for a day of appointments with key state lawmakers; Michigan Governor John Engler is joined at the 1993 signing of the Michigan liability reform bill by, from left, W. Peter McCabe, MD, then-MSMS vice chair; Gilbert B. Bluhm, MD, then-MSMS president; Richard D. Weber, MSMS legal counsel, MSMS Past President Thomas C. Payne, MD, and Thomas E. Stone, MD, chair, MSMS Professional Liability Task Force; Paul DeWeese, MD, Okemos school reform activist, addresses a crowd at a rally; Thomas C. Payne, MD, Lansing radiologist, speaks with Tipper Gore at a community forum on health system reform; Hassan Amirikia, MD, Detroit obstetrician/gynecologist, meets Michigan's U.S. Senator Spencer Abraham.



October 1996 Volume 95, Number 10

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What's at stake and who's running. MSMS will endorse the judicial conservatives most likely to uphold the hard-won Michigan medical liability reforms of 1993.

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LETTERS

MDPAC offers opportunities

I am enclosing a personal check for \$150 for current membership in MDPAC. Although I have been a member of MSMS for many years, I recently had an opportunity to participate in interviews for our local congressional candidates, Congressman Richard Chrysler and his challenger Debbie Stabenow. The experience was very much appreciated and made me appreciate the opportunity we have as MSMS members to become actively involved in the political process and perhaps influence its outcome. I am sorry I have not made a similar financial commitment in the past and look forward to continuing participation through

Don G. Davis, MD

Plastic Surgeon, East Lansing

NIH publishes physical activity recommendations

Last year, the National Heart, Lung and Blood Institute and the Office of Medical Applications of Research of the National Institutes of Health (NIH)

held a Consensus Development Conference on Physical Activity and Cardiovascular Health. The NIH developed a consensus development statement, available to the public, from that conference. To obtain a free copy of the NIH recommendations concerning physical activity, you may write or call NIH Consensus Program Information Service, PO Box 2577, Kensington, MD, 20891, 1-888-644-2667.

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Director of Communications Office of Medical Applications of Research

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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Question:

66 How did you first become involved in the political process? 99

University of Michigan Alumni Association.

Edgar P. Balcueva, MD Internal Medicine, Saginaw

My interest in politics goes back to my college days at Georgetown University in Washington, DC. Hailing from South Dakota, I soon became well acquainted with that

state's senators and congressmen, all of whom were friends of my family. About 30 years ago I went with a group of Oakland County physicians to meet with Representative Bill Broomfield in Washington. Since then, I've been an active sustaining member of MDPAC & AMPAC. It's important to see that friends of medicine get elected, but it's equally important to maintain our continuing relationship to support such items as our tort reform bills, patient protection act, scope of practice".

Peter A. Duhamel, MD

General Surgeon, Rochester Hills

My wife's interest in politics pre-dates mine. She's been active in the local Republican party for years. I would always tag along with her. When I became active in my county society, it made sense for me to get more involved in politics. It's something my wife and I can do together so that makes it more fun. I've donated money, time, gone door-to-door for a candidate, addressed envelopes, made phone calls and signs, hosted receptions and "twisted arms."

Tom George, MD

Anesthesiology, Kalamazoo

66 I became involved in politics when I became a naturalized U.S. Citizen on March 28, 1967. I have contributed to AMPAC this year and plan to continue contributing to further the cause of AMPAC. Locally I have attended presidential campaigns, including a chat with our incumbent governor (I have a picture with him). I have entered as a candidate for a seat on the Board of Directors at Saginaw General Hospital. I have served as president of the local Saginaw Downtown Lions Club and was elected to a two-year presidency of the local

I have been involved in politics for about 10 years. I worked on Governor Engler's re-election campaign committee for the Senate. I write to state and federal representatives and senators regarding various issues at least 2 to 3 times per month. I was an AMA representative for the hospital medical staff for five years. In 1995, I spearheaded an effort to reveal Medicaid reimbursement fees to physicians. In order to do this, we needed to pass a law, which we did. I meet with federal and state elected officials to express my views on a regular basis. I work with the AMA and AAFP on various issues of concern.

John L. Pfenninger, MD Family Practice, Midland

I have had some mild interest in politics since my undergraduate training but have gotten more involved than voting at election time. I think, however, the days of passive involvement are soon ending. With the changing medical environment, such as managed care and government involvement, I believe it is becoming imperative that there is more involvement in the political process. Certainly many physicians are involved but many more, including myself, need to be more active in effecting positive change. Without physician involvement there will be no medical advancement for the patient or physician.

James W. Gerard, MD

Obstetrics/Gynecology, Holland

BackTalk is a nonscientific sampling of Michigan physicians' opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to Michigan Medicine, Back Talk, PO Box 950, East Lansing, MI 48826-0950, or fax to (517) 337-2490, or e-mail jmarr@msms.org.

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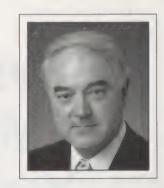
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The liability concerns of managed care groups:

Several insurance products are needed

By Richard D. Weber, MSMS Legal Counsel



O: I have been informed that there are liability concerns that physicians and others must consider in creating and operating physician organizations to compete with other managed care organizations. Are these liability issues different than the kinds of liability physicians have traditionally encountered? A: There are several bases for potential liability that managed care organizations (MCOs) must be aware of. In general, the liability exposure to MCOs can be separated between vicarious and direct liability.

An MCO may be liable for medical malpractice of its participating physicians. If the physicians are employees, the MCO is liable for their negligent conduct or medical malpractice under the legal doctrine of vicarious liability. This doctrine holds employers responsible for negligent acts of employees even though the MCO, as the employer, is otherwise without fault. This liability is similar to the liability imposed upon professional corporations for the malpractice of its employed physicians.

Even if the physicians are not employees of the MCO, the entity may have liability exposure. MCOs may be liable for the negligence of nonemployed physicians under the doctrine of ostensible or apparent agency. Under this legal theory, an

MCO that holds itself out to the public as a health care provider may be liable if health care services are negligently provided, regardless of whether the physician is an independent contractor. This doctrine originated in its application against hospitals, but is being expanded to include multiple models of MCOs.

An MCO may also be liable for its direct or corporate negligence on the basis of its acts or omissions in its corporate capacity. This could include negligent credentialing or negligently monitoring providers. Similarly, MCOs that rely on utilization review organizations could be liable for selecting the organizations without exercising reasonable care to protect subscribers. MCOs could be liable based upon the allegation that coverage was improperly denied through the utilization review process. Subscribers could argue that the denial was negligent or constituted a breach of contract, or that the claim was denied in bad faith. This direct or corporate liability is an exposure to a physician entity that is not typically encountered in traditional

Another potential liability exposure in the new health care world of MCOs is to the directors and officers of the MCOs, typically corporate entities. The law requires that directors and officers are fiduciaries of the corporation and they must act in good faith

and in the best interests of the organization, consistent with the diligence, skill and care of directors and officers in similar situations. The most frequent liability claims against directors and officers involve claims relating to employment relationships, including wrongful termination, discrimination and sexual harassment claims. In addition, claims against officers and directors may be based upon the torts of libel and slander, which involve defamation of character and interference with privacy rights. Such claims against officers and directors could also include antitrust violations and breach of contract claims.

INSURANCE COVERAGE

There are insurance products to protect against the kinds of claims arising out of the operation of physician organizations in the managed care delivery system. To protect the entity against vicarious and direct liability discussed above, errors and omission (E&O) coverage is available. This coverage essentially extends to the business of the MCO and covers personal injury damage as opposed to bodily injury damage, which is essentially covered through general liability insurance. Physicians should be familiar with general liability insurance which should also be part of the MCO's insurance portfolio.

(continued on page 10)

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("Ask Our Lawyer" continued from page 8)

The potential liability assumed by officers and directors discussed above is typically covered by directors' and officers' (D&O) insurance. D&O coverage protects directors and officers from personal liability arising out of claims for failure to perform their fiduciary duties to the corporation and its shareholders and potential claims discussed above, including wrongful termination, discrimination and antitrust violations.

E&O coverage and D&O coverage are separate insurance policies. There are many different policy forms with different coverages and exclusions. Physicians involved with managed care organizations should search out coverage for the kinds of risks discussed in this answer, comparing the breadth of coverage and costs. Both policies should be reviewed together so as to assure proper coverage and avoid over-

Editor's Note: If you have legal questions you would like answered by MSMS legal counsel in this column, jot them down and send them to Judith Marr, Editor, P.O.Box 950, East Lansing, MI 48826-0950.

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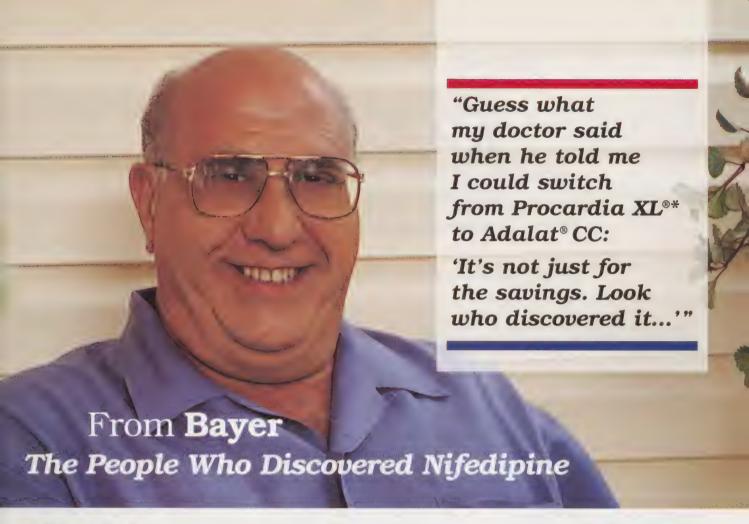
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INFORMATION

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INDICATION AND USAGE: ADALAT (C is indicated for the treatment of hypertension. It may be used alone or in combination with other antihypertensive agent: CONTRAINDICATIONS: Known hypersensitivity to nifedipine.

CONTRAINDICATIONS: Known hypersensitivity to nifedipine.

WARNINGS: Excessive Hypotension: Although in most patients the hypotensive effect of nifedipine is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients using concomianto beta-blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients who received immediate release capsules together with a beta-blocking again and who underwent coronary ratery hypass surgery using high dose fentantyl anesthesia. The interaction with high dose fentantyl appears to be due to the combination of infedigine and a beta-blocker, but the possibility that it may occur with rifedipine alone, with low doses of fentanyl, in other surgical procedures, or with other narcetic analgesisc cannot be ruled out. In infedigine-treated patients where surgery using high dose tentanyl and patients and the surgery completed in the provision should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for nifedipine to be washed out of the body prior to surgery.

Increased Angina and/or Myocardial Infarction: Rarely, patients, particularly those who have severe obstructive coronary artery disease, have developed well downed the interaction upon starting infedipine or at the time of dosage increase. The mechanism of this effect is not established.

Beta-Blocker Withdrawak. When discontinuing a beta-blocker it is important to taper its dose, if possible, rather than stopping abruptly before beginning nifedipine. Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with incrossed majno, probably related to increased sensitivity to caterholamines. Initiation of infedipine treatment will not prevent this occurrence and on occasion has been reported to increase it. Treatment with not prevent this occurrence and on occasion has been reported to increase it. Congestive Heart Failure: Arrely, potients (usually while receiving a beta-blocker) have developed heart failure after beginning nifedipine. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of infedipine would be expected to be of less benefit to these patients, owing to their fixed impedance to flow cross the portic value.

flow across the aortic valve.

PRECAUTIONS: General - Hypotension: Because nifedipine decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and
titration of ADALAT CC is suggested. Gase observation is especially recommended for patients
already taking medications that are known to lower blood pressure (See WARNINGS).

Peripheral Edemo: Mild to moderate peripheral edema occurs in a dose-dependent
manner with ADALAT CC. The placebo subtracted rate is approximately 8% or 30 mg, 12%
at 60 mg and 19% at 90 mg daily. This edema is a localized phenomenon, thought be
associated with vasadilation of dependent arterioles and small blood vessels and not due
to left ventricular dysfunction or generalized fluid retention. With patients whose hyper-tension is complicated by congestive heart failure, care should be taken to differentiate
this peripheral edema from the effects of increasing left ventricular dysfunction.

Haformation for Parlenters. ADALAT CC is an extended release tablet and should be
swallowed whole and taken on an empty stomach. It should not be administered with
food. Do not chew, divide or crush tablets.

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of

tood. Do not chew, divide or crush tablets.

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of enzymes such as alkaline phosphatase, CPK, LDH, ScOT, and ScPT have been noted. The relationship to nifedipine therapy is uncertain in most case, but probable in some. These laboratory obnormalities have rarely been associated with clinical symptoms; however, cholestasis with or without joundice has been reported. A small increase (<5%) in mean alkaline phosphatase was noted in patients treated with ADALAT CC. This was an isolated finding and it revery resulted in values which fell outside the normal range. Rare instances of allergic hepatitis have been reported with nifedipine treatment. In controlled studies, ADALAT CC did not adversely affect serum unic acid, glucose, cholesterol or potnessium. Wilfedipine, like other calcium channel blockers: decreases platelet apareaction in vitro. Wilfedipine, like other calcium channel blockers: decreases platelet apareaction in vitro.

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platetet membrane. Acc clinical significance for these findings has been demonstrated. Positive direct Coombs' test with or without hemohytic anemia has been reported but a causal relationship between infedipine administration and positivity of this laboratory test, including hemolysis, could not be determined. Although infedipine has been used safely in patients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, rare reversible elevations in BUN and serum creatinine have been reported in polinents with pre-exiting chronic trend insufficiency. The relationship to infedipine therapy is uncertain in most cases but probable in some. **Drug Interactions:** Beta-adrenergic blocking agents: (See WARNINGS).

ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placebo-controlled clinical trial. However, there have been occasional literature reports suggesting that the combination of nifedipine and beta-adrenergic blocking drugs may increase the likelihood of congestive heart failure, severe hypotension, or exacerbation of angina in patients with cardiovascular disease.

Server in promission, or exceleration to ringinal in parties with delevated disposition levels, or Digitalis: Since there have been isolated reports of patients with elevated disposin levels, and there is a possible interaction between disposin and ADALAT CC, it is recommended that disposin levels be monitored when initiating, adjusting, and discontinuing ADALAT CC to avoid possible over- or under-digitalization.

that digaxin levels be monitored when initiating, adjusting, and discontinuing ADALATCC to avoid possible over- or under-digitalization.

Coumaria Anticogulants: There have been rare reports of increased prothrombin time in patients; taking commaria anticoagulants to whom nifedipine was administered. However, the relationship to nifedipine therapy is uncertain.

Quinidine: There have been rare reports of an interaction between quinidine and nifedipine (with a decreased plasma level of aquindine).

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Cimetidine: Both the peak plasma level of nifedipine and the AUC may increase in the presence of cimetidine. Ranitidine produces smaller non-significant increases. This effect of cimetidine may be mediated by its known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of infedipine. If nifedipine therapy is initiated in a patient currently receiving cimetidine, courtious titration is advised.

Carcinogenesis, Matagenesis, Impairment of Fertility: Nifedipine was administered arally to rats for two years and was not shown to be carcinogenic. When given to arts prior to mating, nifedipine accused reduced fertility at a dose approximately 30 times the maximum recommended human dose. In vivo motogenicity studies were negative.

Pregnancy: Pregnancy Category C. In rodents, rabbits and mankeys, nifedipine has been shown to have a variety of embrystocity, placentotoxic and fetotoxic effects, including stunted fetuses (rats, mice and rabbits), glipid anomalies (rats and rabbits), with deformities (mice), cleft palate (mice), small placentes and underdeveloped chorionic villi (monkeys), embryonic and fetot deaths (rats, mice and rabbits), protonged pregnancy (rats, not evaluated in other species), a

Importance or the array to the morner.

ADVERSE EXPERIENCES: The incidence of adverse events during treatment with ADALAT (C in doses up to 90 mg daily were derived from multi-center placebo-controlled clinical triads in 370 hypertensive patients. Attended 50 mg once daily was used concominantly in 187 of the 370 patients on ADALAT (C and in 64 of the 126 patients on placebo. All adverse events reported during ADALAT (C therapy were tabulated independently of their causal relationship to medication.

their coust reinfonship to medication.

The most common adverse event reported with ADALAT® CC was peripheral edema. This was dose related and the frequency was 18% on ADALAT CC 30 mg daily, 22% on ADALAT CC 60 mg daily and 29% on ADALAT CC 90 mg daily versus 10% on placebo. Other common adverse events reported in the above placebo-controlled trials include: Headache (19%, versus 13% placebo incidence); Flushing/heat sensation (4%, versus 0% placebo incidence); Disziness (4%, versus 2% placebo incidence), Talique/asthenia (4%, versus 4% placebo incidence); Mausaa (2%, versus 1% placebo incidence); Constipation (1%, versus 0% placebo incidence).

Where the frequency of adverse events with ADALAT CC and placebo is similar, causal relationship cannot be established.

The following adverse events were reported with an incidence of 3% or less in daily doses up to 90 mg:

auss up no ving: Body as a Whole/Systemic: chest pain, leg pain Central Nervous System: paresthesia, vertigo Dermetologic: rash Gustrointestinal: constipation Musculeskeletal: leg cramps Respiratory: opistaxis, rhinitis Urogenital: impo-tence, urinary frequency

Other adverse events reported with an incidence of less than 1.0% were

Other adverse events reported with an incidence of less than 1.0% were:

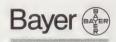
Bedy as a Whole/Systemic: cellulitis, chills, facial edema, neck pain, pelvic pain,
pain Cardiovascular: atrial fibrillation, bradycardia, cardiac arrest, extrasystole,
hypotension, polipitations, phlebitis, postural hypotension, tochycardia, cutaneous angiectaese Central Nervous Systeme: anxiety, contission, decreased libido, depression,
hypertonia, insomnia, somnolence Dermatologia: pruritus, sweating
Gastrointestinal addominal pain, diarrhead, ny mouth, dyspepsia, esophogiis, flatulence, gastrointestinal hemorrhage, vomiting Hematologic: pynaphadenopathy
Metabolic: gout, weight loss Musculoskeletal: arthrafqia, arthritis, myalgia
Respiratory: dyspnea, increased cough, rales, pharyngitis Special Senses: abnornel vision, amblyopia, conjunctivitis, diplopia, tinnitus Uragenital/Reproductive:
kidney calculus, nocturio, breast engargement

The following adverse events have been reported rarely in patients given nifedipine in other formulations: allergenic hepatitis, alopecia, anemia, arthritis with ANA (+), depression, erythromelalgia, exfoliative dermatifis, lever, gingival hyperplasia, gynecomastia, leukapenia, mood changes, muscle cramps, nervousness, paranoid syndrome, purpura, shokiness, sleep disturbances, syncope, taste perversion, thrombocytopenia, transient blindness at the peak plasma level, tremor and urticaria.

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References: 1. IMS NPA+. January 1996. 2. Glasser SP, Ripa SR, Allenby KS, Schwartz LA, Commins BM, Jungerwirth S, on behalf of the Nifedipine Study Group. The Efficacy and Safety of Once-Daily Nifedipine Administered without Food: The Coat-Core Formulation Compared with the Gastrointestinal Therapeutic System Formulation in Patients with Mild-to-Moderate Hypertension. Clin Ther. 1995;17(2):296-312. **3.** Glasser SP, Jain A, Allenby KS, Shannon T, Pride K, Pettis PP, Schwartz L, MacCarthy EP, and the Nifedipine Study Group. The Efficacy and Safety of Once-Daily Nifedipine: The Coat-Core Formulation Compared with the Gastrointestinal Therapeutic System Formulation in Patients with Mild-to-Moderate Diastolic Hypertension. Clin Ther. 1995:17(1):12-29. 4. Adalat® CC Product Monograph, April 1995.

5. Redbook Update. Montvale, NJ, Medical Economics Data, Inc., June 1996.



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Check your biography on the new AMA database

All active, licensed physicians are included

For every year he has been in practice, gastroenterologist Richard Corlin, MD, has paid up to \$8,400 annually for a simple listing in the Yellow Pages with his name, address and phone number. Today, Doctor Corlin has his entire medical biography up on the AMA's Internet Web site, at no cost.

AMA's new program, AMA Health Insight, contains both the new patients' medical "Reference Library" and a new physician information database called "AMA Physician Select."

The AMA database, the most comprehensive listing of all U.S. physicians, lists a physician's education, residencies, board certification and other significant biographical information available. Patients can search the database by physician name, location or specialty.

"Patients can now pop-up on the Internet or head to the public library and find a biography on their physician in a matter of seconds," said Doctor Corlin, speaker of AMA House of Delegates. "You also can search your town by specialty and find a list of all the licensed

"Surfing the Internet" is a monthly feature of Michigan Medicine. If you have a question regarding the Internet, the MSMS home page, MSMSNET, or Voyager Information Services, contact William R. DeCourcy at MSMS via E-mail at bdecourcy@msms. org or by phone at (517) 336-7601.

physicians in the area. This is a great tool for members of the public seeking the best physicians for themselves and their families."

AMA Physician Select

AMA Physician Select is the first database of its kind available to the public. Only actively licensed physicians are included in the AMA's database. Searches can be conducted by 23 major specialties and 150 sub-specialties, and by city, zip code, state or by name. AMA Physician Select provides the physician's name, address, phone number, gender, medical school, all residency and internship information, specialty board certification and AMA membership.

AMA Patient Reference Library

The AMA Patient Reference Library contains information about the AMA and the medical profession and a link to information and resources on diseases, such as the JAMA/HIV AIDS Information Center. The HIV Center features clinical updates, daily news and information on social and policy questions related to AIDS, under the direction of JAMA staff and an editorial board of leading HIV/AIDS authorities.

AMA members receive "expanded web site"

All AMA members are offered an

"expanded web page site" to list additional practice information, including practice philosophy, health plans accepted, hospital privileges, group practice affiliations, personal information, practice hours, and even a photo. All AMA members are also identified in the database by the AMA logo, as are recipients of the AMA Physician's Recognition Award for continuing medical education.

"We expect 30 to 50 percent of patients to use the Internet at home or in local libraries to find out more about their physicians," said Doctor Corlin. "The expanded web pages are much more than a yellow page ad. It's like a brochure placed in the hands of thousands of potential patients."

Check it out!

To find your listing in the AMA Health Insight database, access the AMA's Internet Web Site address at http://www.ama-assn.org. If you need to update your listing there, you may contact the AMA at 312-464-5759.

Find us on-line at http://www.msms.org/



Elections Provide Multiple Opportunities

t's an election year, Doctor, and you're on the spot. It's up to you to support your profession through your vote.

What could be more important than a vote for the Supreme Court candidates who will uphold your decades-long fight for medical liability reforms? Who will you place in the legislature to hear your appeals for the sanctity of the medical profession and the regulation of your practice?

You are not alone in this challenge, however. This month's issue of Michigan Medicine provides you all kinds of help in making your choices and becoming active on behalf of medicine.

You will find here profiles of the "hottest" state legislative races and candidates, as well as a list of all candidates endorsed by your Michigan Doctors' Political Action Committee (MDPAC). You will meet some of your most informed and less hours in your behalf interviewing candidates, campaigning for the best, and describing medicine's concerns to elected officials. And you will be challenged to join them in their noble and often thankless job through opportunities to join MDPAC and to serve as part of the MSMS Physicians Legislative Network.

Read 'em and reap! This is your duty, and it's opportunity you hear knocking. You have much to lose, and everything to gain.

Six physicians who serve.

Taking a personal interest in politics,

By Karen Bouffard

"Because
much of medicine is governed by
government
and regulations, it behooves me to
be part of
making the
decisions."
—Cathy O.
Blight, MD,

In Lansing and Washington, DC, at luncheons and fund-raisers, in committee rooms and back hallways, a corps of dedicated Michigan physicians voice their concerns about managed care, Medicare reform, tort reform, anti-trust law and other issues that significantly affect how medicine is practiced. These are the politically active MSMS members who represent the House of Medicine as our laws, rules and regulations are written. Some are involved out of concern about one or more specific issues. But others are there just to be sure physicians' voices are heard whenever their patients or practices stand to be affected.

According to one physician's estimate, less than one percent of physicians take the time to get involved in legislative efforts. For those who do, the task is both critical and challenging.

> For this election-season issue. Michigan Medicine interviewed six doctors who regularly forego time with their patients and families in order to educate and influence the policy-makers that are shaping the future of medicine. Their stories provide insight into the range of experiences available to doctors making the commitment to political activism. The remainder of the physician population

owes this hard-working group a debt of gratitude.

Leveling the Playing Field

Cathy O. Blight, MD, chair of the MSMS Legislative Policy Committee, wants to make sure the interests of both patients and physicians are protected within the presently-evolving managed care environment.

"So much of medicine is governed by government and regulations that, in order to ensure protections for patients and for how I want to practice medicine, it behooves me to be part

of making the decisions - or at least to educate and influence the people who make them," says Doctor Blight, a pathologist with Hurley Medical Center in Flint.

Doctor Blight says the Michigan Patient Bill of Rights, currently under discussion in the legislature, would help protect patients within the new environment of managed care. There also is a need to reform anti-trust guidelines to level the playing field for physicians, she says.

"The day and time for people saying 'I only practice medicine, I don't have time' are over," she adds.

"The world of physicians is being shaped, and we need to be there to educate the people who are making the decisions."

But Somebody's Got to Do It

Petoskey family practitioner Louis R. Zako, MD, likens political activism to one job most of us could do without.

"It's not nearly as much fun as patient care, or golfing or bicycling, but it's a necessary part of what we do as physicians," says the former chair of the Michigan Doctors Political Action Committee (MDPAC).

Doctor Zako has been politically active for 25



Cathy O. Blight, MD, left, meets with Rep. Deborah Cherry (D-Burton)

of his 35 years as a physician. He was introduced to politics through the MSMS "Doctor for a Day" program, which sends physicians to Lansing to testify on health bills, attend fund-raisers and meet with lobbyists, an experience which was "a real eye-opener" for Doctor Zako.

"I didn't realize how many interest groups wanted to influence how medicine is financed-industrial unions, farm bureaus, chambers of commerce, trial lawyers, auto manufacturers ..."

Among Doctor Zako's top priorities are tort reform, a problem he finds "so huge you almost need a revolution to get back to a sense of balance or equity," and the commercialization of healthcare.

"Treatment should be decided by patients, their physicians and their physicians' consultants - not by Wall Street investors. Legislation for a Patient Bill of Rights or protection acts are the right approach."

Doctor Zako notes that only about one percent of physicians are politically active, although their involvement is crucial to the future of healthcare. He adds, "If we don't do it, then let's not moan and groan when somebody else takes control of our medical decision-making."

Defending the Defenseless

As an obstetrician-gynecologist with a large, urban practice in Southfield and Detroit, Cecil B. Jonas, MD, felt compelled to become involved in politics because of the dismal infant mortality rate among the primarily poor, black population he served.

How, he wondered, could more doctors be recruited to serve the poor, if they couldn't be promised adequate reimbursement for their services? How many doctors could be expected to take on these riskiest of patients without adequate protection from liability?

"The infant mortality thing was the real incentive that catapulted me to action," he says.

Care of the poor is still a major issue, Doctor Jonas says. "The major players are different, and



MMS member Tom George, MD, Kalamazoo, right, held a fundraiser for Senator Dale Shugars (R-Portage), center. At left is Paul Stevenson, MD, Kalamazoo

the issues have shifted, but it's still an ongoing problem."

Doctor Jonas is concerned about the effects of current Medicaid reconstruction on physicians who have established practices among the poor.

"Now there are big dollars in taking care of the poor," he says. "The big hitters are scrambling to set-up slick organizations to convince Lansing they can do the best job of it. If care of the poor is bid out to the most competitive, I don't see how we can compete against the smooth, well-heeled initiatives that can afford the lawyers and the glossy brochures.

"We have to be sure that the traditional players and those who have taken care of the poor for many years can compete. Otherwise there is a real chance of completely losing our practices they'll be vacuumed up."

"I don't know how this will all be played out. Only time will tell - but stay tuned."

Trying to Make a Difference

Inad Haddad, MD, an internal medicine physician from Adrian, has always had a personal interest in politics. "I have always wanted to try



Doctor Zako



Doctor Jonas



"It's important to interview and support political candidates so that strong relationships are in place when officials take office." -Inad Haddad, MD, Adrian Cong. James Barcia (D-Bay City) seated, receives a Michigan physician delegation in his Washington, D.C., office. From left, Peter A., MD, and Lois Duhamel of Rochester, Jack, MD, and Arline Barry of Saginaw, Suzie Pederson of Midland, Krishna K. Sawhney, MD, of Taylor, Hassan Amirikia, MD, of Detroit, Inad Haddad, MD, of Adrian, Michael Sandler, MD, of Detroit, and W. Peter McCabe, MD, of Grosse Pointe

and make a difference - to make things happen,"

Doctor Haddad became involved in the mid-1980s when tort reform was a major issue. He participated in the October 1985 "March on Lansing," organized to voice doctors' dissatisfaction with the malpractice crises, and has stayed involved since.

"Physicians need to be aware that our future depends on our degree of involvement in shaping policy in the State Capitol and in the halls of Congress," he says. "We either become involved in that process, or have other people make the decisions for us."

A former president of the Lenawee County Medical Society, Doctor Haddad says becoming active at the county level is a good way to get involved. It's important to interview and support political candidates, he adds, so that those relationships are in place when officials take office.

"This is a time of constant change for our profession," Doctor Haddad says. "We have to be part of that change in order to survive it to our liking."

"The future of medicine is going to be decided not in medical schools and hospitals, but at the State Capitol and Washington, DC."

Protecting Michigan Patients

Mark D. Kolins, MD, immediate past chair of the MSMS Committee on State Legislation and Regulation, said he literally has a "file drawer" full of issues that warrant his attention as a physician. Of those, one that particularly concerns him is the regulation of interstate medical prac-

"Currently, physicians who are not licensed in the state can practice medicine via the Internet or telephone. Tissues may be sent out of state and diagnosed by physicians who are not licensed in Michigan," says Doctor Kolins, an anatomical and clinical pathologist with Beaumont Hospital in Trov.

"If they don't have a medical license in Michi-

gan, the Michigan Board of Medicine has no jurisdiction," he says. "We need to require that those physicians follow our rules if they want to practice in Michigan."

Doctor Kolins says the issue was debated at the MSMS House of Delegates meeting in April. The MSMS Board discussed the matter



Doctor Kolins

again in July and decided to move forward by developing proper language for legislation and recruiting a legislative sponsor.

"This is a growing issue," Doctor Kolins says. "There are a handful of states that have addressed it - but we're in the first quarter of the group. It's hard not to get excited about being involved."

Doctor Kolins urges physicians who'd like to get involved to call MSMS.

"Let them know you're interested, and they'll find you a committee assignment - certainly at the county level if not at the state level," he says. "MSMS has the structure to give physicians access to legislators so that we can discuss these issues."



Doctor Payne

One Physician Makes a Difference

Thomas C. Payne, MD, tells a story to illustrate how one physician can influence political decision-making. It has to do with a legislator who was expected to vote against the MSMS position on a particular issue.

"It came time for the vote, and lo and behold, he voted our way," Doctor Payne recalls. "So one day I asked him, `What the heck happened?' As it turns out, his own ophthalmologist had taken 10 minutes to talk with him."

"This physician didn't even realize he'd made a difference, but he had."

Doctor Payne, a radiologist with Michigan Physicians Mutual Liability Company, first got involved in politics in 1976 when he was president of the Ingham County Medical Society. MSMS invited him to join the then-"Doctor of the Week" program. After spending a week brown-bagging with legislators, testifying before committees and attending fundraisers, Doctor Payne was hooked.

"I got interested in it and pursued it," he says. Doctor Payne says it takes time to develop ongoing relationships with legislators. "When we get to a critical time, we can use these contacts to make a difference," he says. "When you know legislators as individuals and friends, you can talk to them in greater detail."

Doctor Payne, past president of MSMS, is one of the state's hardest-working and most dedicated

physician activists. He spends considerable time educating legislators about health-related issues and interviewing political candidates to determine their viewpoints. Last year he interviewed 16 candidates in one night, and so far this year, he has interviewed about 33. He adds that there will be a great need for physicians to interview candidates in 1998, since 83 out of 110 state legislators will be ineligible for reelection at that time because of term limitations.

"Physicians need to make themselves aware of the races, meet with legislators and attend the meetings of their county medical societies," he says. "Mechanisms have been put into place to give physicians an opportunity to be politically active."

"There is a place for our voice to be heard."

The author is a Williamston, Michigan-based freelance writer.



Kathy and Steve Ledtke, MD, left, supported Cherie and State Senator Dane DeGrow (R-Port Huron) at a recent fundraiser.

Hot seats contested.

Here's the low-down on the candidates to watch this fall.

his November Michigan constituents will have some crucial choices to make in deciding who will serve as their voice in Lansing. MSMS has identified the following races as 10 "hot" races for physicians to watch. The following candidates are among many running for office who have supported organized medicine's issues. These races, however, are close, due to base votes and prior voting patterns in their districts.

Sandy Hill, R-Montrose, 47th District

Representative Sandy Hill, R-Montrose, defeated a six-year incumbent in 1992 and currently



is serving her second term after a hard-fought victory in 1994. Her seat is the number one targeted seat by both parties to gain control of the House.

Rep. Hill introduced legislation which requires HMOs to implement the

American Association of Pediatrics and American College of Obstetricians & Gynecologists guidelines for post-partum stays. She serves as Assistant Majority Whip and is majority vice-chair of the Conservation, Environment & Great Lakes Committee. She has been involved with the Agriculture & Forestry, House Oversight & Ethics and Insurance committees.

The co-owner of Montrose Orchards, a family-owned farm, Rep. Hill has provided community leadership. She sat on the Genesee County Farm Bureau Board of Directors, serving as president from 1984-1989. For two years she was a member of the Michigan Farm Bureau State Policy Development Committee.

Beverly Bodem, R-Alpena, 106th District

Representative Beverly Bodem, R- Alpena, a member of the House Republican Task Force on Health Care Reform and strong supporter of the Michigan Patient Bill of Rights, currently is serving her third term.

Rep. Bodem was appointed by Governor Engler to the White House Conference on Travel & Tourism and serves as chair of the Tourism & Recreation Committee. She is also a member of the House Republican Task Force on Senior Policy.

An active community mem-

ber, Rep. Bodem has served on boards of the Alpena General Hospital Auxiliary, the Alpena League of Women Voters and Big Brothers/Big Sisters of Alpena. She also was chair of the Thunder Bay Arts Council Sculpture Committee for the Bi-Path and a



member of the Zonta Club of Alpena.

James R. Ryan, R-Redford Township, 16th District

First-term Representative Jim Ryan, R-Redford Township, a key sponsor of legisla-



tion which requires HMOs and insurance companies to enact universal claims standards, finds himself in the number two targeted seat for control of the House.

In his first term, Rep. Ryan holds leadership positions as assistant majority whip and as

majority vice-chair of the Public Utilities Committee. He is a member of the Judiciary & Civil Rights and Senior Citizens & Veterans Affairs committees. Because of his extensive work, Ryan received Legislator of the Year honors from the MI Association of Chiefs of Police and the Law Enforcement Coalition.

Michael J. Griffin, D-Jackson, 64th District

Representative Michael J. Griffin, D-Jackson, a loyal advocate for physician issues, was elected to the House of Rep-

resentatives in 1972.

A current member of the Commerce and Health Policy committees, Rep. Griffin has served as chair of the City Government and Elections committees, as well as the Joint Committee on Administrative Rules.



In addition to committee work, Rep. Griffin has been involved in many areas of state government reform, sponsored the 1988 Recreational and Environmental Bond program and created the original "Drug-Free School Zones" act.

Tom Alley, D-West Branch, 103rd District

Representative Tom Alley, D-West Branch, a supporter of liability reform, currently is serving his ninth consecutive term in office.

Rep. Alley has been an accessible lawmaker



who supports the medical community's position on health care issues. He is currently the minority vice chair of the House Conservation. Environment and Great Lakes Committee as well as a member of the Legislative Council. He also held leadership positions in his com-

munity as the West Branch Township Supervisor, past Chair of the Ogemaw County Democratic Party and former member of the Democratic State Central Committee.

Michael J. Goschka, R-Brant, 94th District

Representative Michael J. Goschka, R-Brant, defeated former House Speaker Lew Dodak in November 1992 and currently is serving his sec-

ond term in office.

Since winning office, Rep. Goschka has given MSMS the necessary votes to pass liability reform. He has served on the Tax Policy, Agriculture and Tourism committees. In 1990, Gov.



John Engler chose Rep. Goschka to serve on the Governor's Leadership Team, a responsibility Goschka continues to fulfill.

Rep. Goschka's community involvements include operating as chair of the Jack Kemp for President campaign from 1986-88 and serving as a member of Farm Bureau of Michigan and United Steelworkers of America.

Sharon L. Gire, D-Mt. Clemens, 31st District

Representative Sharon L. Gire, D-Mt. Clemens, co-sponsor of the Michigan Patient Bill of Rights, has served in office since 1987.

As minority vice-chair of the Human Services committee, as well as a member of the Education and Health Policy committees, Rep. Gire's education in social work and education has proven vital. She also has served as assistant



Democratic leader for the 1995-96 legislative session, chair of the Human Service and Children, Social Services and Youth and Constitution and Women's Issues committees.

Before committing to state government, Rep. Gire served as Macomb County

Commissioner, Mount Clemens City Commissioner and Mount Clemens Mayor, pro-tem.

Agnes M. Dobronski, D-Dearborn, 15th District

Representative Agnes M. Dobronski, D-Dearborn, currently is serving her fourth term in the House of Representatives.

Rep. Dobronski worked full-time with the Dearborn school system while earning her

bachelor's and master's degrees. After retiring from Dearborn schools in 1980 after 37 years of service, she took a position as legislative director for the Michigan Retirement Coordinating Council in Lansing.



Since her first term in office in 1987, Rep. Dobronski has maintained an open-door policy for her constituents. She has consistently supported physicians' health care concerns.

Peter Lund, R-Harrison Township 26th District

Macomb County Commissioner Peter Lund, will challenge William Callahan for the 26th Dis-



trict seat left vacant because of current Democratic Representative Tracey Yokich's retirement.

Lund's supporters believe the recent restructuring of the 26th district, giving it a greater Republican make-up, offers him an excellent

chance to capture the House seat. While campaigning for office, Lund has expressed a broad understanding of health related issues and physicians concerns on such matters.

A Macomb County native, Lund is currently an adjunct professor at Walsh College in the Department of Finance and Economics.

Thomas C. Mathieu, D-Grand Rapids, 76th District

Representative Thomas C. Mathieu, the author of several legislative bills which have allowed for health care liability reform to oc**cur,** has served 22 years in the House of Representatives.

Within several years of taking office, Rep. Mathieu held positions as Majority Whip and Assistant Majority Floor Leader. He also authored the Mathieu-Gast Home Improvement Act, Home Heating Assistance Act and the law

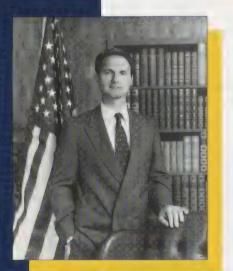


creating the Civilian Conservation Corps. Among his honors are: the Michigan United Conservation Clubs' 1979 Conservation Legislator of the Year; the Michigan Federation of Private Child and Family Agencies' 1987 and 1988 Legislator of the

Year; and the Association of Independent College and Universities 1984 Distiguished Services Award.

During earlier political involvements, Rep. Mathieu was former Director for Community Development for the Kent Community Action Program; former director of West Side Complex Neighborhood Center, a member of the Grand Rapids Community Relations Commission and United Fund committees.

Vote Dr. Greg Shannon for County Clerk



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Join medicine's volunteer team

You could bring in your candidate's winning votes.

By Donna Welch LaGosh

here are many ways in which an individual, or a group, can be involved in a political campaign and help to make a difference in the outcome. Volunteers can make or break a campaign! No successful campaign is waged without the assistance of many unpaid supporters who are willing to devote their time and energy to the candidate.

The Michigan State Medical Society (MSMS) is helping to fill that need with a volunteer network for endorsed candidates of the Michigan Doctors' PAC (MDPAC), the political action committee for MSMS. Following are ways in which you can volunteer to support MDPAC's endorsed candidates. If you are interested, please contact Donna Welch LaGosh at 517-336-5788.

Work on a phone bank

Phone banks are often a continuing project of any campaign. At the very least, there will be operating phone banks as part of the Get out the Vote (GOTV) effort just before and on election day. You can volunteer on one of the campaign phone banks, or you can offer to help organize a phone bank with colleagues, neighbors, or friends. The campaign will assist you with materials should you desire this type of project.

Use your office as an endorsement

As a physician, you talk to hundred of patients and their families. Your opinion is well respected in the community. You can help the candidate just by placing a campaign sign your office. This can initiate discussion and give you an opportunity to talk about your support of this candidate.

Become a door-to-door spokesperson

Because a candidate cannot talk to everyone in person about his/her candidacy, it is important to have spokespeople who can speak to individuals on behalf of the candidate. Usually, a group of individuals is organized to cover a neighborhood and go door-to-door handing out cam-

paign literature and asking people to support the candidate.

Send a letter of support

A letter from you to your friends and colleagues about why they should support your candidate is an effective campaign tool.

■ Become an election day volunteer

On election day, there are hundreds of campaign workers on the job for every type of campaign. You can become a part of the volunteer team. Election day activities include: phone banks, on-site polling, literature distribution, or providing transportation to individuals unable to get to their voting location. Each campaign will offer guidance and assistance to volunteers.

■ Volunteer for the state party

Another option for those who would like to help on a broader scale is to talk with the director of field operations at the Democratic or Republican state party offices. They have a well-organized team of field staff who can always use volunteers for various projects.

■ Get involved!

Any of the above mentioned activities does not require a huge time commitment. Any time you can donate will be much appreciated by the campaign and the candidate. The important thing to remember is to GET INVOLVED! Elections have been won by one vote. Your efforts could mean the difference between victory and defeat.

The author is chief of Political Affairs for the Michigan State Medical Society.

No more back-room deals

PACs unite average Americans around common interests

Scene - late on an August night in 1969 in the House office building. A lone man holding a small bag slips down the hallway in the dim light. He stops before the Congressman's office door, with its transom window conveniently open. The bag fits easily through the opening over the door and drops with a thud on the other side, to be discovered in the morning by a loyal staffer. Such is the way one more contribution was made to Congressman Doe's campaign fund.

Although this scene is fictitious, similar incidents reportedly occurred during the "good old days," involving backslapping, smoke-filled back rooms and the exchange of suitcases full of money. With the creation of the 1974 Federal Elections Campaign Act, Congress changed all that by eliminating back room bargaining and strengthening our political process by formalizing PAC regulations. These new campaign finance laws limited contributions, disclosed the source, and in the process opened the door to involving hundreds of thousands of individuals in the political process.

There are some, however, who would outlaw PACs, calling this organized form of involvement, "special interest money." They say that by doing so they will return our democratic process to the individual, average American citizen.

But political action committees ARE groups of "individual, average American citizens" who band together around common interests in support of candidates who share their views. And PACs play several important roles in our elections.

First, PACs provide a healthy and diverse mix of money in the democratic process. PACs cross all lines of the political spectrum, from the far left to the far right, from business to labor, from doctors to teachers, and from environmentalists to gun control advocates. These groups have all pooled their money to help elect legislators who would best represent their concerns in government.

Each interest deserves to be represented in government, regardless of whether they are striving to save the whales or obtain what they feel would be a more equitable tax system. PACs provide these diverse individuals' voices with one stronger voice, thus ensuring that their views can be heard.

Second, other facets of our election system could take a lesson from PACs. Political action committees are limited in their campaign contributions and are fully disclosed. They serve as a model for the rest of the system. If other campaign and election activities, such as soft money, were regulated, recent funding abuses would not have occurred or would have been less onerous.

One of the most important aspects of PACs, however, is the involvement of millions of Americans in our electoral process through their PAC contributions, as well as accompanying political education and grassroots programs.

PACs provide valuable information through political education programs. To most citizens, civics courses are but a dim memory; however, PACs and political education programs provide a refresher course on government, and enable members to understand that a congressman in California has an impact on their jobs or business in the mid-west. Or how a provision in current legislation will affect their ability to do business, and significantly impact their lives.

Political education provides the knowledge and tools to be informed, involved and active citizens.

PACs have proved to be a healthy development in providing a voice for many and stimulating political education and involvement - all in the open.

Reprinted from the 1995 Winter issue of AMPAC's Stethoscope.

Doctor Jones goes to Lansing

MSMS Board member Jeffrey M. Jones, MD, Battle Creek, center, is among the many MSMS members who make political activism part of their schedules. At a recent visit to the Capitol in Lansing, Doctor Jones met with Governor John Engler, left and Rep. Eric Bush (R-Battle Creek). Physicians' regular conversations with local legislators and the governor are an important part of assuring that medicine's views and needs are known. For more on how to be active, blease see the accompanying articles in these pages. A single call from a single physician can change a single vote that can win an election or pass a bill!

For questions, contact Donna at 517/336-5788.



MICHIGAN Doctors' Political Action Committee 1996 Volunteer Election Exchange

This is a critical time for physicians and alliance members to be involved in election activities. Thank you very much for your willingness to donate your time on behalf of organized medicine.

-Krishna K. Sawhney, MD Chair, MDPAC

Please complete the information below and return to: Donna Welch LaGosh, 120 W. Saginaw, E. Lansing, MI 48823. Telephone _____ Name Address House Representative Would you prefer to volunteer (check as many as you would like): Afternoons Mornings Eveninas Election Day Before Election Day For a State House candidate For a Supreme Court Candidate Once your form has been received, we will coordinate your volunteer time with the candidate. You will be consulted in advance as to your availability. The time commitment would only be two to three hours, unless you wish to do more.

MDPAC lists endorsements

These candidates for statewide office are endorsed by MDPAC

Prunning for election this fall to Michigan's state government. These hardworking, dedicated volunteers have surveyed the candidates for you, asking the questions you would ask, to determine the candidates' views and stances on everything from Medicare and Medicaid reform to physician-assisted suicide. They have reported their findings from those interviews to the MDPAC board. The following is the list of candidates, by district, whom MDPAC members have endorsed as best serving physicians' viewpoints. They deserve your vote in November.

District 2 - Curtis Hertel, D

District 4 - Ed Vaughn, D

District 5 - Ted Wallace, D

District 6 - Martha Scott, D

District 7 - Raymond Murphy, D

District 8 - Ilona Varga, D

District 9 - Kwame Kilpatrick, D

District 10 - Samuel Buzz Thomas, D

District 11 - Morris Hood, Jr., D

District 12 - Keith Stallworth, D

District 13 - Burton Leland, D

District 14 - Derrick Hale, D

District 15 - Agnes Dobronski, D

District 16 - James Ryan, R

District 17 - Thomas Kelly, II, D

District 18 - Eileen DeHart, D

District 19 - Lyn Bankes, R

District 20 - Gerald Law, R

District 21 - Deborah Whyman, R

District 22 - Gregory Pitoniak, D

District 23 - Edward Nykiel, R

District 24 - Joseph Palamara, D District 25 - Robert DeMars, D

District 26 - Peter Lund, R

District 27 - Nick Ciaramitaro, D

District 29 - Dennis Olshove, D

District 30 - Sue Rocca, R

District 31 - Sharon Gire, D

District 32 - David Jaye, R

District 33 - Alvin Kukuk, R

District 34 - John Freeman, D District 35 - David Gubow, D

District 36 - Nancy Quarles, D

District 38 - Nancy Cassis, R

District 39 - Barbara Dobb, R

District 41 - Shirley Johnson, R

District 42 - Greg Kaza, R

District 43 - Hubert Price, Jr., D

District 44 - David Galloway, R District 45 - Penny Crissman, R

District 46 - Tom Middleton, R

District 47 - Sandra Hill, R

District 49 - Robert Emerson, D

District 50 - Deborah Cherry, D

District 52 - Mary Schroer, D

District 53 - Elizabeth Brater, D

District 54 - Kirk Profit, D

District 55 - Bev Hammerstrom, R

District 57 - Tim Walberg, R

District 58 - Michael Nye, R

District 59 - Glenn Oxender, R

District 61 - Charles Perricone, R

District 62 - Eric Bush, R

District 63 - Donald Gilmer, R

District 64 - Michael Griffin, D

District 65 - Clyde LeTarte, R District 66 - Judith Scranton, R

District 67 - Dan Gustafson, R

District 68 - Lingg Brewer, D District 69 - Lynne Martinez, D

District 70 - Laura Baird, D

District 70 - Laura Baird, D

District 71 - Frank Fitzgerald, R

District 73 - Jack Horton, R

District 74 - Ken Sikkema, R District 75 - William Byl, R

District 76 - Thomas Mathieu, D

District 77 - Harold Voorhees, R District 79 - Bob Brackenridge, R District 80 - James Middaugh, R District 81 - Terry London, R District 83 - Kim Rhead, R

District 84 - Mike Green, R District 85 - Larry Julian, R

District 86 - Alan Cropsey, R District 87 - Terry Gieger, R

District 88 - Patricia Birkholz, R

District 89 - Jon Jellema, R District 90 - Jessie Dalman, R

District 94 - Michael Goschka, R

District 95 - Michael Hanley, D

U.S. Congress

U. S. Senate - Ronna Romney, R

District 1*

District 2 - Peter Hoekstra, R

District 3 - Vernon Ehlers, R

District 4 - Dave Camp, R

District 5 - James A. Barcia, D

District 6 - Fred Upton, R

District 7 - Nick Smith, R

District 97 - Howard Wetters, D

District 98 - James McNutt, R

District 99 - Jim McBryde, R

District 100 - John Llewellyn, R

District 101 - Bill Bobier, R

District 102 - John Gernaat, R District 103 - Tom Alley, D

District 104 - Michelle McManus, R

District 105 - Allen Lowe, R

District 106 - Beverly Bodem, R

District 107 - George Kinsella, R

District 109 - Michael Prusi, D

District 110 - Kathy Stupak-Thrall, R

District 8 - Dick Chrysler, R

District 9 - Dale Kildee, D

District 10 - Suzy Heintz, R

District 11 - Joe Knollenberg, R

District 12*

District 13*

District 15 - Carolyn Cheeks Kilpatrick, D

District 16*

*Interviews have not been held in these districts.

Paul Fecko, MD

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Ophthalmology - Kresge Eye Institute

Dear Fellow MSMS members:

Lawyers have embraced the political process and subsequently wield significant political power. Physicians have disdained the political process and are chagrined by their lack of political influence. State Senator Joe Schwarz, my classmate, has challenged physicians to become politically active at all levels of government. I have accepted his challenge, and seek an office requiring statewide election.

My only hope of success statewide is with your help. I need physicians in every county to volunteer to display my campaign literature and urge their patients to vote November 5, 1996.

I can be reached at my office (810) 642-5223, or my home (810) 644-6366.

Sincerely,

Paul Fecko, MD



'No more pivotal election' in 1996.

State Supreme Court holds liability reform in its hands.

By Krishna K. Sawhney, MD

ichigan physicians' support is needed now to ensure the right candidates are elected in November to the Michigan Supreme Court.

What is at stake is the 1993 medical liability reform legislation for which MSMS battled decades. With the reform's constitutionality being challenged by the trial lawyers, the Supreme Court judges' rulings will determine the viability of the reform laws.

MSMS will support candidates who are likely to uphold the laws as they stand rather than rewrite them. By the time this issue goes to press, MDPAC will have endorsed its favored candidates based on interviews scheduled September 26 in East Lansing by the Alliance for Judicial Accountability, a coalition of organizations founded in 1994 to educate the public on the Supreme Court races.

Five candidates, as different as Matisse and Max or Pavarotti and Presley, are asking voters to elect them to the Michigan Supreme Court this year.

In most election years, Supreme Court campaigns are overshadowed by higher-profile statewide or national contests. But 1996 is different. Bill Ballenger, editor of Inside Michigan Politics newsletter, observes: "There is no more important, critical, pivotal—whatever word you want to use—election this year than for the Michigan Supreme court."

Majority control

For the first time in two decades, the Nov. 5 elections will almost certainly determine which political party seizes majority control of the High Court.

For many years, the court has been made up of three justices nominated by Republicans, three nominated by Democrats, and one self-proclaimed independent, Justice Charles Levin.

But Levin has reached age 70 and, under the constitution, can't seek another term. That creates on open seat. The other seat up for grabs is held by Chief Justice James Brickley, a Traverse City Republican, seeking his third term.

If justices nominated by Democrats take Levin's open seat and

upset Brickley, they'll hold the court 5-2. Even if they pick up only Levin's open seat, they'll take the court 4-3.

Candidates nominated by the GOP face a daunting task: they must win both seats to gain 4-3 control. If that happens, and Republicans also retain their majority in the state House of Representatives, the GOP will control all three branches of state government. In recent years, the state's GOP-led Legislature and Governor have approved numerous reforms that help businesses create jobs and reduce costs, and help protect access to affordable health care.

Impact of Employers and Health Care **Providers**

A political fact of life is Supreme Court candidates nominated by Democrats tend to enjoy the support of organized labor and the state's trial bar. That's because Democratic candidates for the high court—including both 1996 nominees -have been active in the Michigan Trial Lawvers Association (MTLA) or labor unions, or at least have been sympathetic to their issues.

Justices with these kinds of credentials scare employers and health care providers. If the MTLA and labor union-backed nominees win this year, employers and health care providers fear that reforms made in the 1994-95 and 1995-96 legislative sessions will eventually be undone by the high court.

The Candidates

Both parties nominated two candidates at their state conventions in early September. The Republicans chose Brickley and Oakland County Circuit Judge Hilda Gage. The Democrats picked two state Appeals Court judges—William Murphy of Grand Rapids and Marilyn Kelly of Bloomfield Hills.

Murphy is a former small business owner and a past president of the MTLA. Kelly is still active in the MTLA and has long enjoyed the support of the state's major labor union.

The fifth significant candidate is Oakland County Circuit Judge Jessica Cooper, who collected enough signatures to win a ballot spot without the blessing of one of the major parties. Cooper fancies herself "the independent voters should want."

Political watchers believe the most likely outcome on Nov. 5 includes a Brickley win and a victory by Murphy or Kelly.

Differences

Each of the five candidates carries solid credentials that qualifies them for the job. However, their records on the bench and philosophies suggest significant differences in how they view—and rule on—disputes over laws important to health care providers and employers.

This fall, the Alliance for Judicial Account-

ability (AJA) will meet with the five candidates, then prepare articles, a brochure and other tools with information about the candidates' past rulings to help MSMS members make informed decisions on Nov. 5.

Doctor Sawhney is MSMS Board chair and chair of MDPAC.

MDPAC endorses Brickley and Gage

After reviews of their backgrounds and personal interviews September 26 in East Lansing, MDPAC endorses Republican nominees James H. Brickley and Hilda Gage for the Michigan Supreme Court. Brickley currently serves as Michigan Supreme Court Chief Justice. Hilda Gage is currently the Oakland County Circuit Judge. Both candidates are expected to maintain recent liability reforms.

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Il interested Michigan physicians are invited to this comprehensive conference exploring issues in health professions education. Topics will include financing, use of needs assessment models, state government regulation, the impact of managed care and future planning.

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Global Capitation Rates

A Survival Primer for Capitated Environment—Part 2

By Kevin Cawley

his article is the second of a two-part series in Michigan Medicine designed to provide Michigan physicians with a framework to approaching capitation. Capitation in healthcare financing consists of risk transfers from insurers to providers for cost and utilization of services via fixed prepayment. Unfortunately, a fairly large number of physician practices currently are searching for a starting point on capitation processes in these rapidly evolving times. The focus of the first article (September 1996 Michigan Medicine) was on primary care and specialty subcapitation; this article addresses global capitation arrangements.)

At first blush, the concept of pursuing global capitation seems absurd. After all, could there be any greater admission of failure for a managed care organization than to arrange for someone else to manage all care? Why might physician organizations feel they could succeed where so many others have clearly failed? What motivates physician organizations and payers to pursue capitation?

Capitation Rewards

Here are some of the answers. For physician groups that are entrepreneurial and believe that they are superior care managers, global capitation is a method of capturing more of the insurance premium dollar with corresponding greater rewards. From a payer perspective, these arrangements offer the opportunity to align some financial incentives between the payer and PO as well as shift risks that are generally incompatible with existing payer bureaucratic structures, while still maintaining a reasonable margin. For payers and willing POs, then, these arrangements can create a win-win situation.

Developing Capitation Environments

Global capitation opportunities are coming to

Michigan physicians from two direction--HMOs and other MCOs, through broad risk pools for virtually all services, and Medicare and Medicaid legislation focusing on Provider Sponsored Networks (PSNs). As it turns out, there are more common than unique considerations to both opportunities.

To seriously consider entering into a global capitation arrangements, physicians must be organized into some form of group and must have significant primary care capability to facilitate overall care management. The minimum size of the group and its delivery model are subject to

a variety of considerations and debate that will only be answered with any certainty over time. In evaluating if a group or practice is a candidate for global capitation arrangements, it is vital to have first gone through the six-step process of surviving subcapitation described in part one of this series. Of particular importance is understanding the group's existing revenue stream.

After that, physicians should analyze more than one year's experience with the managed care payer that is under consideration for a global capitation arrangement (preferred data is at a CPT-4 code level for physician and outpatient services and DRG for inpatients). Has the group's performance been reasonably consistent? Have there been significant variations? Are the variations attributable to unusual cases (controllable through stop-loss insurance), or are they less readily identifiable? How does the group's performance compare to others practicing with the MCO (if not individually, then in aggregate form)? How does the performance compare with external benchmarks (either realtime services of consulting actuaries or printed manuals)? Does the group feel that it is possible

What motivates physician organizations and payers to pursue capitation?

to reduce use of non-group providers through better management of services?

If the answers to these questions generally are favorable, then the group is probably ready to develop a global capitation agreement with the payer. If the answers are generally unfavorable, the evaluation of cause is important to the group's survival.

Do not overlook the obvious. Situations such as pediatric intensivists practicing both in their specialty and as a primary care physician, and new family practitioners setting up offices in underserved obstetrical markets have fouled up more than one MCO's data analysis. Detailed information from the MCO facilitates the process of identifying causes, because it can then be matched against detailed external data bases.

Strategies for contracting capitation arrangements

For groups considering global capitation arrangements with MCOs, there are many considerations in contracting but three strategies to warrant specific mention:

- A-Limit risk associated with any individual case through stop-loss insurance or other risk transfer with the MCO. While in subcapitation arrangements, group risk is generally limited to time and effort that can be expended on one patient in a given specialty, global risk opens up an enormous downside for specialty care, facility services and pharmaceuticals that must be expressly limited.
- B-Develop consistent incentives for both the MCO and the group. For example, while percentage of premium arrangements might seem to provide that kind of consistency, a preponderance of fixed core costs would create incentives for some MCOs to garner market share via premium reductions without any corresponding new enrollment for the group.
- C-Comparison shop all services for which

the MCO is providing prices. This includes, but is not limited to, stop loss insurance, out-of-area costs, network fees, as well as the overall percentage of premium kept by the MCO.

Some aggressive POs are considering taking the next step, particularly for serving medicare as well a Medicaid patients, but also conceivably in the self-insured employer market. That next step, of course, cuts the MCO out of the clinical and administrative loop in care delivery. This approach is based on the premise that PO structures may be capable of providing virtually all the services of an MCO at a lower cost, or comparable cost. The MCO's profit margin would then also be available to the PO as well.

Challenges to physician organizations

There are three major challenges to POs that are interested in pursuing this option. The first is simply a provider network. In order to deliver comprehensive health care services, those gaps in the capability of the PO must be filled by either recruitment or contract. Given the probable growth phase of a PO considering global capitation, subspecialists in general would have to be contracted and primary care physicians recruited. Other specialists would vary with the size of the market served. Of course, the professional component is only one side of the equation. Network development also would need to include facility services, mental health, home health, pharmacy and durable medical equipment. While most services can be quite readily "shopped" to a variety of providers in most markets, facility services would be more difficult, owing to facility monopoly or oligopoly power in most markets.

The second major challenge would be the introduction of some key administrative processes. Certainly among those are various capitation administration processes (establishing risk pools and payment mechanisms), claims payments, customer satisfaction, enrollment, A group must understand it's revenue stream before entering an agreement.

Typically, HMOs need at least 25,000 to 50,000 enrollees to operate successfully.

credentialling, quality assurance and utilization review. These services can either be developed in house or contracted to various other entities such as TPAs, MSOs, actuarial firms, consulting and accounting firms and data management firms.

Lastly, to aggressively pursue commercial and Medicare patients, a significant marketing effort to enroll these patients is required. In terms of real hurdles to direct contracting, this may be the largest. Medicaid patients under the new Medicaid global capitation program are expected to take somewhat less of a marketing effort, particularly for those physicians with a reasonable volume of PSP patients now. Losses incurred in large scale marketing efforts can be staggering; and yet without significant enrollment, network development (particularly with hospitals) is very difficult at any feasible rates.

For small group practices, this effort is probably not realistic. In general, estimates for minimum enrollment for successful HMOs run between 25,000 and 50,000 enrollees. If a similar number is not reasonably attainable for a given group, a logical extension would be to explore relationships with other groups to attain the mass necessary to serve a market of that size. An alternative would be to establish relationships with other groups to allow for the simulation of such enrollment in member months over a longer time horizon. Capitalization for such an effort (using HMO models) would range upwards from a minimum of \$2,000,000. Where marketing efforts are difficult, that figure would rise nearly exponentially.

For additional information about capitation rate development, recommended reading would include How To Negotiate Capitation (without losing your head) by Philip L. Beard and Calculated RISK, a Provider's Guide to Assessing and Controlling the Financial Risk of Managed Care by Bruce S. Pyenson. For additional information about other readings, companies or services, please contact MSMS.

The author is chief of MSO Development for MSMS.

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The Art of the Cheap Thriller

By Roy S. Goodman, MD

I once read that people whose lives are important and interesting don't feel that they have to read "important" literature. If that's true, I must have a pretty interesting life because virtually everything I read, outside of medical material, is strictly escapist fare. Most of it falls into a category you could call "cheap thrillers," the genre that made Robert Ludlum a household name.

Your average thriller is strictly predictable. The bad guys are out to do something truly horrendous; the good guy has to figure it out and save the world, usually while participating in a fair amount of sex. Sometimes the hero must fight a natural catastrophe instead of human villains, sometimes both at once. And even though you know it's going to work out in the end, you enjoy seeing how.

Of course there are some bad thrillers and plenty of average ones. Over the years I've discovered a few that I consider far above average—books that I would recommend to anyone.

Probably the most famous example is *The Boys From Brazil* by Ira Levin. It's got everything—the Fourth Reich, the ever-popular Dr. Joseph Mengele, and Levin's excellent writing—and I've read it and enjoyed it several times.

There are others, equally good, that are not nearly as well known. Some are out of print, but if you can find a copy it will reward your search.

The cover blurb for William Overgard's *The Divide* (Jove, 1980) says it's "in the tradition of SS-GB by Len Deighton." Like the Deighton novel, *The Divide* takes place in a world where the Axis has won the Second World War, but the similarity stops there. *The Divide* takes the familiar concept of the National Redoubt—fanatical Nazi survivors hiding in a mountain stronghold until they can emerge for a new attempt to conquer the world—and stands it on its head. Here it's the Americans who are hiding in a National Redoubt and the German occupying troops who think it's just a rumor. At

every turn I found myself thinking "that's the way it would have been." The characters and their struggle are believable, and the book has a much needed touch of humor.

Richard Ben Sapir is best known to thriller afficionados as one of the authors of the popular "Destroyer" series. (Yes, I admit I have read a few of them. I enjoy

the subtle humor that tempers the mindless violence.) If you saw his name on a book called *The Body* (Star, 1985) you'd probably judge it by the cover—and you'd misjudge it completely.

A routine dig in Jerusalem uncovers a burial sight that matches the details of Jesus' burial but the bones are all there, the body didn't rise from the grave. This could be a major blow to Christian beliefs, so the government of Israel calls in the Vatican, and the Vatican calls in a most unlikely hero—Father James Folan, SJ, an obscure administrator at Boston College. The Body isn't just about Father Folan's quest to discover whether the relics are real; it's a cerebral thriller about archaeology, Judaism, Catholicism, faith, belief, and humanity. It's never boring, thanks to Sapir's magnificent command of his many subjects, his believable dialogue, and his understated sense of humor. You don't have to like escapist fiction to enjoy *The Body*.

If Alastair MacLean in his prime had gotten together with a hard-science science fiction author, the result might be "Space Station Zebra." This book actually exists as *Endgame Enigma* (Bantam, 1988) by James P. Hogan.

Some time in the not-too-distant future, the Soviets orbit a huge space station. Its purpose is allegedly peaceful, but the Western intelligence community has dire suspicions and sends agents to investigate. The agents manage to get aboard with cover identities as reporters. Are the Soviets up to no good? Do you even have to ask? How they conceal the truth, and how the agents break



through the deception, form a fascinating tale of wheels within wheels within wheels (literally as well as figuratively). You may find Endgame Enigma with the science fiction (if you can find it at all) but you don't have to enjoy SF to love this one.

You'll probably find Gloryhits (Del Rey, 1978) with the SF as well. But this is bioscience fiction. written by a pair of PhDs: biochemist Bob Stickgold and geneticist Mark Noble. Aside from Flashman novels (also heartily recommended) it's the only escapist fiction I've ever seen that has footnotes!

The cover blurb says "they had wantonly tampered with the basic genetic DNA," and experienced thriller readers will easily guess that this is even more serious than changing the formula for Coca Cola! Most of the characters in Gloryhits are biologists, and the authors involve them with a dire biological threat. The writing starts out a little awkward, but once the scientists begin doing science the characters are in their element and the novel becomes very involving. The world view in this novel is paranoid, almost gleefully paranoid. But as the authors point out. they may be paranoids with real enemies!

For some reason computer crime has received very little attention in the world of fiction. The Fool's Run (Signet, 1990) by John Camp is a very satisfying exception. If Robert Ludlum were interested in technology he could have created the intricate plot.

Paul Erdman has a near-monopoly on economic thrillers, but Thomas Hoover goes him one better in The Samurai Strategy (Bantam. 1988), the tale of an all-out economic attack on the United States masterminded by a Japanese businessman with the brains, the ven, the connections, and the nerve to bring it off. Erdman is the better writer, but Hoover mixes more excitement into the world of commerce. As a businessman and the author of two nonfiction works about Japanese philosophy, he knows his material. Read The Samurai Strategy before shopping for your next car—and then buy a domestic model!

The author is an otolaryngologist in Waterford, Michigan.



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AMA President visits Kalamazoo

Daniel H. "Stormy" Johnson, MD. Metairie, LA. radiologist and president of the American Medical Association, addressed 100 Kalamazoo Academy of Medicine members and their guests in mid-July. He is flanked, above, by W. Peter McCabe, MD, left, MSMS president, and Donald H. Batts, MD, KAM president. Doctor Johnson, who was well covered by the local media, called for expanded choices for today's patients, whom he believes must be "put in the driver's seat." He supported legislation to create medical savings accounts as one of the expanded choices.

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October is Breast Cancer Awareness Month

Physicians aid women through state cancer control program

By Cathy L. DeShano

Awareness Month by Governor John Engler, this is a good time to celebrate the fifth year of an important statewide program through which Michigan physicians help improve the health status of Michigan women.

When the Michigan Department of Community Health received a five-year, \$3 million-per-year grant from the US Centers for Disease Control in 1991, the state took an important step towards reversing the overall mortality rate from breast and cervical cancer among low-income women.

Each year, about 1,600 Michigan women die

from breast cancer; cervical cancer causes an additional 160 deaths. However, yearly screenings with follow-ups of abnormalities would prevent one-third of all breast-cancer deaths and almost all cervical cancer deaths, according to the Michigan Department of Community Health. Through the 1991 Michigan Breast and Cervical Cancer Control Program (BCCCP), qualified women can receive reduced-cost

screening services and some necessary diagnostic procedures. Since its inception, the statewide program has provided clinical breast exams, pap smears, pelvic exams and mammogram screenings to over 33,000 women. Any woman who is at least 40 years-old and earns an income less than 250 percent of federal poverty guidelines may go through the program. For many women, the program allows a first chance to receive these services.

"Very few women have a good understanding of these health issues," said Robyn Grinzinger, BCCCP coordinator for the Central Michigan District Health Department.

Kathy Kline, MD, Mt. Pleasant, is just one physician who has provided guidance for both patients and health department staff. Doctor Kline, a radiologist who stains, screens and reads pap smear slides, became involved with BCCCP when she took a position with Central Michigan Community Hospital about two years ago. Having cared for underserved Alaskan natives, Doctor Kline encourages other physi-

cians to get involved because "no matter how people get their health care, whether through a private practice, a hospital or clinic, it's equally important," she urges.

The program emphasizes this point, requiring screening facilities to meet guidelines as established through the federal Mammograph Quality Standards Act and the Clinical Laboratory Improvement Amendment so that all involved are "operating by the same standards as hospitals like the University of Michigan or Johns Hopkins would," said Doctor Kline.

While the equipment and methods used meet the stringent national standards, other distinctive differences exist for those physicians and facilities serving low-income women. BCCCP providers often receive less money for the same services they provide to women who exceed the BCCCP income requirements or are covered by insurance. Physicians and facilities can bill insurance companies for those women who carry insurance; for low-income women without insurance, physicians can bill the BCCCP and be reimbursed at close to the Medicare rates for covered screening and diagnostic services. If a woman screened through the BCCCP is diagnosed with breast or cervical cancer, the local health department is responsible for arranging for treatment regardless of the woman's ability to pay for the services. There are no state or federal dollars to pay for treatment. However, BCCCP coordinators have found many physicians and hospital facilities willing to participate.

Continued on page 62



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Other

HUR	SDAY MORNING, NOV.14
I	Legislative Breakfast (7:00 a.m 8:15 a.m., No
F	Fee)
8:30 a.1	m. to Noon, including break)
(Cholesterol and Cardiovascular Disease
F	Female Urinary Dysfunction
F	Frequently Encountered Neurological Problem
I	mmunizations For A Lifetime
S	Stress Management Skills for Physicians
/	What's New In General Surgery

FRIDAY MORNING, NOV. 15 "Early Bird" Plenary Session

"Use and Misuse of Bacterial Resistant Antibiotics' (7:15 a.m.-8:15 a.m., No Course Fee) (8:30 a.m. to Noon, including break) Asthma and Rhinosinusitis: When to Refer Atrial Fibrillation and Myocardial

Revascularization Common Hand and Wrist Disorders: Pediatric Emergencies Sexually Transmitted Diseases (STD)

FRIDAY LUNCH (NO FEE)

FRIDAY AFTERNOON, NOV. 15

(1:30 p.m. to 5 p.m., including break) Allergy and Immunology Update

Common ENT Problems for Primary Care

Computer Basics and Introduction to the Internet Diagnosis and Management of Benign Anorectal Disease

Unconventional Coronary Risk Factors Violent Patients: Care and Clinician Safety

SATURDAY MORNING, NOV.16

"Early Bird" Plenary Session "The Web and Beyond' (7:15 a.m. - 8:15 a.m., No Course Fee)

(8:30 a.m. to Noon, including break)

Intermediate Computers and Advanced Internet Information

Low Back Pain and Alternatives in Management Management of the Red Eye in the Primary Care

Screening, Diagnosis and Treatment of Prostate

Team Management of the Child with Learning Difficulties

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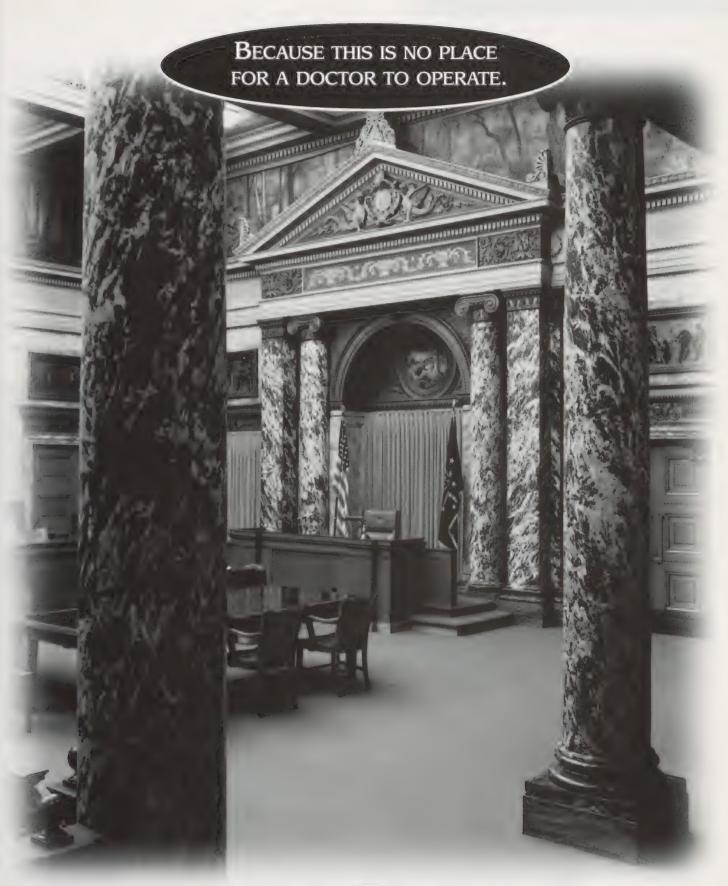
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Paul DeWeese, MD

Prime mover in Michigan education reform.

By Joan Richardson

he little school operated by the Church of the Messiah on Detroit's east side could hardly have known in the early 1980s the role it would play in shaping Michigan education.

Paul DeWeese, then a medical student at creation of a voucher program. Currently, the Wayne State University and now a relentless. indefatigable hustler on behalf of school choice in Michigan, watched the school from afar as he attended services there each Sunday.

"The school was really a resource of hope and opportunity and comfort in what was otherwise a very bleak landscape. The school was safe. It was inviting. It was warm and the children were learning," he says.

Then the school closed. Even though the program, Doctor DeWeese tuition was modest, it still was more than families of students could afford.

"These kids were just assigned to public schools. They were just picked up and plopped down into schools that their parents didn't respect. And their parents had no control over those decisions. The parents felt their kids were schools help people see being lost to them," he recalls.

Watching the disappointment of those parents what it could look like to triggered numerous questions for Doctor DeWeese, questions that continued to mount as he moved into his professional life as a Lansing internist.

"I began to ask why. If we had a school that Michigan Academy, a was working for children, couldn't it receive some of the public money that society sets aside for education?"

In 1990, to transform his beliefs into political action, Doctor DeWeese founded TEACH Michigan Education Fund, an organization committed to changing Michigan's constitution to allow children to receive a tax-funded scholarship (generally known as a voucher) to model schools for lowattend the school of their choice.

In the voucher program as he envisions it, lowincome children would be eligible to receive a board of an organization

set amount of money--probably about \$2,500 per year--that could be used to pay tuition at a private school, possibly including parochial schools as well.

Voters must approve changing the constitution to allow the

Michigan Constitution prohibits spending any public money in private schools. Doctor DeWeese hopes that initiative will be on Michigan's ballot in

As a way to build support for a voucher put TEACH resources behind the 1995 effort to pass a charter school law in Michigan and to create the Michigan Center for Charter Schools. "Charter choice operating. They see have vouchers in this state," he says.

He serves on the board of directors for the Midcharter school on the grounds of the former Michigan School for the Blind in Lansing. The school is in partnership with the Edison Project, a high-profile national project trying to create income children. Doctor DeWeese also is on the

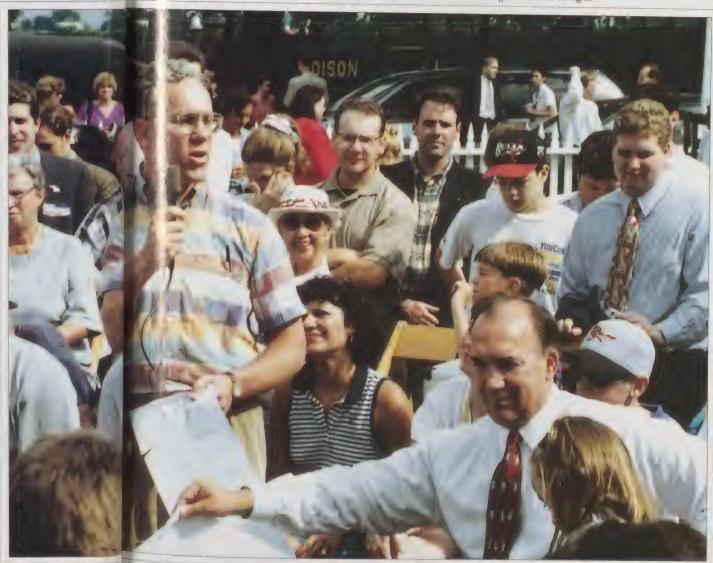
trying to create an Edison school in Detroit.

In order to devote himself nearly full time to the cause of school choice. Doctor DeWeese moved from the practice of internal medicine into emergency medicine nearly 10 years ago. That gave him more defined work hours and the chance to have his days free for the political meetings he needed to pursue his cause.

"My identity is not so much as a physician anymore. Now, I identify myself as someone whose life is devoted to making life better for lowincome children," he says.

The author is a Grosse Pointe Park, Michiganbased freelance writer.

Unctor DeWeese, standing, addresses a crowd on school choice. Governor Engler is seated at right



NEWSMAKERS

Doctor Andy Hunt honored

The founding force behind Michigan State University's College of Human Medicine, Andrew D. Hunt, Jr., MD, has been honored with an endowed lectureship in his name.

The Cornell Medical School graduate began his academic career as assistant professor of pediatrics at New York University College of Medicine. During eight of his 16 years there, Doctor Hunt also was an instructor and assistant professor at the University of Pennsylvania School of Medicine and director of Pediatric Services at Hunterdon Medical Center in New Jersey. He left New York University to accept a newly created position,

director of Ambulatory Services, at Stanford University.

Throughout these years, Doctor Hunt observed his patients reacted best to treatments when biomedical, psychological and social features were exercised. Though many medical experts resisted the

pediatrician's then-radical innovations, Doctor Hunt employed his vision when he left Stanford in 1964 to establish the College of Human Medicine at MSU.

As dean of the College, Doctor Hunt implemented a curriculum which integrated biological, behavioral and social sciences equally. Students completing the program

focused on both the patients' emotional and physical well-being, while training in community hospitals rather than academic medical centers.

The Andrew D. Hunt, Jr., MD, Endowed lectureship honors the

founding Dean's innovations and accomplishments. Each year, a scholar in medicine and the humanities will deliver a significant lecture which relates the Hunt vision of medical education to the current needs and environment of the health care system.



Doctor Richard rejuvenates Grand Rapids clinic

Six years ago, the state government threatened to close down the Cherry Street Health Services Clinic in Grand Rapids because of funding and a need for stricter management. Today, Robert C. Richard, MD, has rejuvenated the Health Services program, work which earned him a position on Governor Engler's Public Health Advisory Council.

Doctor Richard applied for an assistant director position of the Health Services upon the urging of a colleague. Within several months of getting the job, he became director of the clinics and now com-

mands the daily operations of the Health Services' four community clinics.

When the University of Alabama Medical School graduate became director, he hoped to provide quality health care to the underserved population. During the last four years, he has quintupled the number of employees to over 100, among them on-site nutritionists, medical social workers and GI surgical specialists, who see the 4000 patients who visit the Health Services each month. Citing a need for improved interaction with the underserved, Doctor Ri-

chard employed translation and transportation services.

Pleased with the Health Services progress, Doctor Richard continues to adapt his objectives to meet the health care environment's concerns. As attention on school based healthcare has increased, the clinics have implemented medical and dental screenings at school. As president of the Region 5 Clinician Network, Doctor Richard addresses the underserved population's evolving needs, an endeavor for which the Michigan Primary Care Association recently presented him the Distinguished Service Award.



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PEOPLE

Madelon K. Krissoff, MD, has been appointed to the board of the Public Museum of Grand Rapids. Doctor Krissoff, an internal medicine specialist, is currently a member of MSMS, the AMA, the AMWA, the American Society of Internal Medicine and the American Geriatrics Society.

Orthopedic surgeon Ronald B. Irwin, MD, is a new member of the

William Beaumont Hospital Board of Directors. He also is president-elect of the Beaumont Hospital medical staff



and director of the Musculoskeletal Tumor Service in Royal Oak. Doctor Irwin, an orthopedic oncology specialist, has a private practice in orthopedic surgery in Beverly Hills.

Neurosurgeon Alexa Canady, MD, an associate professor of neurosurgery at Wayne State Medical School, is the 1996 Humanitar-



ian of the Year of the Detroit area March of Dimes. Doctor Canady, a leader in the field of children's brain injury, is Chief

of Neurosurgery at Children's Hospital in Detroit. Her honors and involvements include the Michigan Women's Historical Center and Hall of Fame Contemporary Life Achievement Award, the YWCA of Minneapolis 1981 Woman of the Year Award, and membership in the AMA, MSMS and Wayne County Medical Society.

George Blum, MD, an associate professor of pediatrics at Wayne State Medical School, has been named editor of the Michigan Pediatric Update.

Deaths

Former family practitioner and All-American wrestler Harold T. Donahue, MD, died April 28. He was 90. After delivering more than 4000 babies, Doctor Donahue retired from medicine in 1992 with more than 59 years of service to the Cass City area. An active member in the community, Doctor Donahue was nominated Cass City Citizen of the Year. Doctor Donahue received his medical and undergraduate degrees from the University of Michigan, where he also led a successful wrestling career. Captain of the U of M wrestling team from 1927-28, Doctor Donahue finished 3rd in the 1928 US Olympic trials.

Pediatrician **Krikor Ficici, MD**, Troy, died June 21. He was 65. A Turkish native, Doctor Ficici received his medical degree from the University of Istanbul, then spent a year fighting for the Turkish Army before emigrating to the US. The Troy doctor worked at Children's Hospital of Detroit and was a member of the Detroit Pediatric Society.

Former board member of the Oakland County Medical Society, James E. Henderson, MD, died August 3. He was 77. Doctor Henderson, Traverse City, was an obstetrician/gynecologist with St. Joseph Mercy and Pontiac General hospitals. He was a member of the AMA and the American College of Obstetriccians/Gynecologists. Concerned with the interests of senior citizens, Doctor Henderson joined the AARP and the American Association of Senior Physicians.

Herman J. Linn, MD, of Fairfax, CA, died June 7. He was 84. Doctor Linn, a former pathologist at William Beaumont Hospital, graduated from Rush Medical School at the University of Chicago. He was a member of the American Medical Association, the American So-

ciety of Clinical Pathology, the College of American Pathology and the Michigan Society of Pathologists.

Ann Arbor ophthalmologist John W. Smillie, MD, died August 5. He was 80. Doctor Smillie served in the Medical Corps of the US Army and the US Public Health Service before opening a private practice at St. Joseph Mercy Hospital, where he worked for 25 years until retiring. The Cornell Medical School graduate was an alternate delegate to the MSMS House of Delegates and as a past officer and member of the Washtenaw County Medical Society Executive Committee, the Michigan Ophthalmological Society, and the American College of Surgeons.

New Members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Bradley D. Bastow, DO, South Haven

Thomas V. Bilisko II, MD, Kentwood

Stephen B. Brown, MD, West Branch

Zenaida B. Cardenas, MD, Sandusky Cathy Chen, MD, Flint

Joan H. Cheng, MD, West Bloomfield

Uma Cherukuri, MD, Bay City

Kyle P. Christiason, MD, Marquette

Frank W. Crast, MD, Benton Harbor

Evelyn E. Del Rosario, MD, Flint

Lisa G. Dietz, MD, Commerce Twp.

PEOPLE

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MSMS Members Keeping Active

The Michigan State Medical Society would like to recognize the following members who sit on the Boards of associations around the state. They are:

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If you know of other active MSMS members, please send their names to Editorial Assistant Cathy DeShano, MSMS, P. O. Box 950, East Lansing, MI 48826-0950, or e-mail Cathy at cdeshano@msms.org.

Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Surinday S. Bedi, MD, 2207 Belchery Court, Clearwater, FL 34624.

Action, Date Taken: Reinstatement Denied, 7-26-96.

Name: Stephen Schweinsberg, MD, 25307 Dequindre Rd, Madison Heights, MI 48071

Action, Date Taken: Relicensure Denied, 7-26-96 Reason: Failure to Meet Continuing Licensing ReName: Joseph Natole, Jr., MD, 4701 Towne Centre, Suite 103, Saginaw, MI 48604

Action: License suspended - 3 mo. Upon reinstatement, License Limited - min. 3 mo. Upon reclassification to unlimited license, probation - min. 2 years. Fine - \$50,000.00. 8-29-96.

Reason: Negligence - Incompetence.

Name: Joseph Natole, Jr., MD, 4701 Towne Centre, Suite 103, Saginaw, MI 48604.

Action, Date Taken: By Order of the Saginaw County Circuit Court, the Final Order of the Board of Medicine dated 7-30-96 and effective 8-29-96 is Stayed.

quirements



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We encourage individual practices, hospital department meetings and county medical societies to further educate themselves on vaccines.

Please Call Kathy Holcomb, Coordinator at 517-336-5707 or e-mail to kholcomb@msms.org or Jean Capriotti at 517-336-5706 or e-mail to jcapriotti@msms.org.

Peer Education Project on Immunization Immunization Education for Health Providers

EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

November

11-13, Clinical Reviews 1996. Location: Mayo Civic Center, Rochester, Minnesota. Contact: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First St. SW Rochester, MN 55905. Phone: 1-800-323-2688. Fax: 507-284-0532. Approved for: 20 Category 1 AMA credit hours. Registration fee: \$295.

14-17, APS's 15th Annual Scientific Meeting "Pain and Disease: Causes, Consequences, and Solutions." Location: Sheraton Washington Hotel, Washington, D.C. Contact: APS Conference, PO Box 682, Glenview, IL 60025-0682. Telephone: 847-375-4715. Fax: 847-375-4777. Approved for: Up to 25.25 credit hours; 4 credit hours/course. Fees for entire conference: APS member-\$265; Nonmember-\$365. Professional development course fee for physicians: \$50. Breakfast sessions: \$25. Students, residents, and fellows, please contact the APS continuing education office.

14-17, 43rd Annual meeting of the Academy of Psychosomatic Medicine, "Consultation-Liaison Psychiatry: Back to Basics." Location: Hyatt Regency Hotel, San Antonio, TX. Sponsor: Academy of Psychosomatic Medicine. Contact: Academy of Psychosomatic Medicine, (312) 784-2025. Approved for: 23.5 hours of Category 1 credit. Fees: \$295 pre-registered

APM member; \$400 pre-registered non-member. Pre-Registration Deadline is October 25, 1996. Fees will be higher after that date.

16, Brachytherapy for Localized Prostate Cancer: A Promising New Frontier. Location: Sinai Hospital, Zuckerman Auditorium, Detroit from 8 a.m. to 2:30 p.m. Sponsor: Sinai's Prostate Cancer Program. Contact: 313-493-5119. Approved for: 5 Category 1 CME credits.

December

7, Thirteenth Annual CME Clinical Update in Pulmonary Medicine. Location: Trump Plaza Hotel and Casino, Atlantic City, NJ. Sponsor: Department of Pulmonary Medicine, Deborah Heart and Lung Center. Contact: Roberta Silver, Center for Bio-Medical Communication, Dumont, NJ, 07628. 201-385-8080. Approved for: 7 Category 1 CME credits. Fees: \$175 until October 25; \$50 higher after the 25th.

8-11, American College of Cardiology 24th Annual Williamsburg Conference on Heart Disease. Location: Williamsburg Conference Center, Williamsburg Lodge, Williamsburg, VA. Contact: American College of Cardiology, Attn: EP, PO Box 79321, Baltimore, MD 21279-0231. Fees: ACC members before November 22-\$450; Non-members before November 22-\$545. Regis-

trations after November 22 will be handled on-site and fees will be \$50 higher. Reduced fees are available for some individuals.

11-13, Neurology for the Non-Neurologist. Location: Swissotel Chicago. Contact: Office of Continuing Medical Education, Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina #520, Chicago, IL 60612. 312-942-7119. Approved for: 1-20 Category 1 CME credits. Fees: \$425.

13-15, American College of Cardiology 14th Annual Advances in Heart Disease program. Location: The Sheraton Palace Hotel, San Francisco Hotel. Contact: American College of Cardiology. Telephone: 1-800-253-4636, ext. 695. Approved for: 16 category 1 credit hours. Fees: Members who register before 11/29-\$430; Non-members who register before 11/29-\$505. Registrations after November 29 will be handled on-site and fees will be \$50 higher. Reduced fees are available for some individuals.

13-15, "29th Annual New York Cardiovascular Symposium." Sponsor: American College of Cardiology. Location: New York Hilton & Towers, New York, NY. Contact: ACC, 800-253-4636, ext 695. Approved for: 19 hours of Category 1 credit. Fee: \$485 ACC member if registered before Nov 29; \$575 non-member if registered before Nov 29. Registrations after November 29 will be handled onsite and fees will be \$50 higher.

EDUCATIONAL OPPORTUNITIES

January

13-17, The American College of Cardiology's 28th Annual Cardiovascular Conference at Snowmass. Location: Snowmass Conference Center, Snowmass, CO. Contact: American College of Cardiology, Attn: EP, PO Box 79321, Baltimore, MD 21279-0231; phone 800-253-4636, ext. 695. Approved for: 22 Category 1 credit hours. Fee: ACC MEMBER-\$495 by December 30; Non-member-\$600 by December 30. Registrations after December 30 will be handled on-site and fees will be \$50 higher. Reduced fees are available for some individuals.

24-26, The American College of Cardiology 16th Annual Perspectives on New Diagnostic and Therapeutic Techniques in Clinical Cardiology. Location: Buena Vista Palace, Walt Disney World Resort, Lake Buena Vista, FL. Contact: American College of Cardiology, Attn: EP PO Box 79321, Baltimore, MD 21279-0231; phone 800-253-4636, ext. 695. Approved for: 15.5 Category 1 credit hours. Fee: ACC Member by January 10-\$440; Non-member-\$515 by January 10. Registations after January 10 will be handled on-site and fees will be \$50 higher. Reduced fees are available for some individuals.

February

15-16, "Infertility: Evaluation & Treatment for the Primary Care Physician." Location: Sheraton Palace Hotel, San Francisco, CA.

Sponsor: Center for Bio-Medical Communication. Contact: Center for Bio-Medical Communication, 201-385-8080; e-mail: cbcbiomed@aol.com Approved for: 10.5 hours of Category 1 credit. Fee: \$495 physicians; \$295 residents and allied health professionals.

21-26, The American Academy of Allergy, Asthma and Immunology, American Association of Immunologists and Clinical Immunology Society Joint Meeting. Location: San Francisco. Contact: 1997 Joint Meeting Secretariat American Academy of Allergy, Asthma and Immunology, 611 E. Wells St., Milwaukee, WI 53202, USA. Phone: 414-272-6071. Fax: 414-276-3349. Approved for: Up to 35 credit hours.

March

14-15, "Current Issues in Cancer Prevention, Detection & Treatment." Location: Siebens Medical Building, Mayo Foundation, Rochester, MN. Sponsor: Mayo Foundation. Contact: Registars, Mayo Foundation, Section for CME, 800-323-2688, FAX: 507-284-0532. Approved for: 9.5 hours of AMA Category 1 credit. Fee: \$195.

June

26-29, Clinical Magnetic Resonance Society Annual Meeting. Location: Walt Disney World SWAN, Disney World/EPCOT Center, Orlando, FL. Contact: 800-

823-2677 or 513-221-0070; fax 513-221-0825; email *cmrs@one.net* **Approved for:** 25 AMA/PRA Category 1 Hours, 25 Category A CE.

ONGOING

Case Studies in Environmental Medicine. Location: Your office/ home (self-instructional monographs). Sponsor: The Agency for Toxic Substances and Disease Registry, Division of Health Education. Contact: Michele Borgialli, Michigan Department of Community Health, Division of Health Risk Assessment, PO Box 30195, Lansing, MI 48909, 517-335-9647. Approved for: Up to 33 hours of free Category I credits; 1 per case study. Trump Plaza Hotel and Casino, Atlantic City, NJ. Sponsor: Department of Pulmonary Medicine, Deborah Heart and Lung Center. Contact: Roberta Silver, Center for Bio-Medical Communication, Dumont, NJ, 07628. 201-385-8080. Approved for: 7 Category 1 MCE credits. Fees: \$175 for until October 25; \$50 higher after October 25.

MSMS Meetings

November

- 7. MSMS Capitation Seminars. Location: MSU Educational Center, Trov. Contact: Darla Brandon at MSMS at (517) 336-5769.
- 13, MSMS Capitation Seminars. Location: Hyatt Regency, Dearborn. Contact: Darla Brandon at MSMS at (517) 336-5769.
- 14-16, MSMS Annual Scientific Meeting. Location: Lansing Center, Lansing. Contact: Patty Bokovoy at MSMS at (517) 336-7729.
- 20. Board of Directors Meeting. Location: MSMS Headquarters, East Lansing. Contact: William E. Madigan at MSMS at (517) 336-5734.
- 20, MSMS Capitation Seminars. Location: Amway Grand Plaza Hotel, Grand Rapids. Contact: Darla Brandon at MSMS at (517) 336-5769.
- 21, Michigan Health Professions Education Conference. Location: Radisson Hotel, Lansing. Contact: Sherry L. Fent at MSMS at (517) 336-5730.

January

15, MSMS Board of Directors Meeting. Location: MSMS Headquarters, East Lansing. Contact: William E. Madigan at MSMS at (517) 336-5734.

AMA Meetings

October

30-Nov. 1, AMA Conference on Family Violence: Building a Coordinated Community Response. Location: Oak Brook Hills Hotel, Oak Brook, IL. Contact: Kerry Stewart or Debora Buggs at (615) 399-9908.

November

8-11, American Medical Association Interim Meeting. Location: Atlanta, Georgia. Contact: Judy Marr at MSMS at (517) 336-5744.

Michigan Specialty **Society Meetings**

October

- 17, Michigan Ophthalmological Society (MOS) Academic Meeting. Location: Radisson Hotel, Southfield. Contact: Andy Lott at MSMS at (517) 336-7589.
- 18-20, Michigan Society of Medical Assistants Fall Seminar. Location: Van Dyke Park Place Hotel, Warren. Contact: C&D Executives, 37831 Terri Crest Dr., Sterling Heights, MI 48310, email: CZARNED@AOL.COM

November

- 6, Michigan Dermatological Society Regional Scientific Meeting. Location: Wayne State University, Detroit. Contact: Jennifer Anibal at MSMS at (517) 336-7595.
- 7, Michigan Society of Pathologists Meeting. Location: Dearborn Inn, Dearborn. Contact: Melissa K. Wiegand at MSMS at (517) 336-7586.
- 21, Graduate Health Professions Conference. Location: Radisson Hotel, Lansing. Contact: Sherry L. Fent at MSMS at (517) 336-5730. Co-sponsored by MSMS.

December

4, Michigan Dermatological Society Regional Scientific Meeting. Location: Wayne State University, Detroit. Contact: Jennifer Anibal at MSMS at (517) 336-7595.

January 1997

31-Feb. 2, Michigan Society of Medical Assistants Midwinter Seminar. Location: McCamly Plaza Hotel, Battle Creek. Contact: Sue Storey, CMA-C, 2336 Ramblewood Dr., Kalamazoo, MI 49009.

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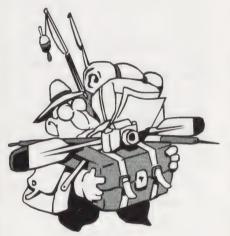


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"Breast Cancer" (continued from page 40)

"I have all but one surgeon and two obstetricians/gyne cologists in my area participating," said Barbara Rivenburgh, BCCCP Coordinator, District Health Department #2. "I also have all three hospitals for the four area counties involved."

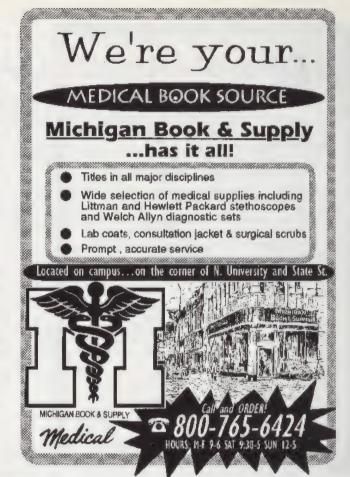
For John Girardot, MD, Battle Creek, becoming involved posed a question of community responsibility rather than financial obligations.

"If you make your living in the community, you've got to take care of the people. Most of these people have no funding of any kind; they're not eligible for Medicaid," said Doctor Girardot. "Community service is part of the duty."

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For additional information about the Michigan BCCCP, contact Carol Garlinghouse, MSN, RN, at the Michigan Department of Community Health at 517-335-9616. ■

The author is Michigan Medicine editorial assistant.



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We must not fail our patients in their final hour



By W. Peter McCabe, MD

went to a funeral a few weeks ago that was both a celebration of what our profession can be at its best, yet also a disquieting warning about what we could become if we don't keep our values in perspective.

The deceased was my uncle and godfather, Reginald A. Allen, MD, known to everyone in the family as "Doctor Reggie." He was 90 when he died, clear-minded and in great health until the last year of his life. He practiced pediatrics until he was 82, but knew his limitations and, in the latter phase of his career, limited his practice to, well, baby pediatrics.

In a way he represented as close as I had to a medical role model, and, in a sense, he inspired me to pursue medicine. I was a bit of a hypochondriac as a kid, with the slightest stomach cramp signaling a premature death. But I can well remember Doctor Reggie making a house call, coming into my bedroom with a bemused, but never deprecating, air of control, concern and confidence and, after a thorough exam, taking some magic potion out of his big black bag. Suddenly the future would again look bright. And off he would go on another house call in his '47 Ford coupe with the big search lights next to the driver's windshield.

Frankly, he was such an accom-

plished physician that I went to him up until my mid-twenties, though I must admit I snuck in the back door of his office. So it wasn't surprising that his funeral was a well-attended one, considering his age, with many past patients filling the church. During his sermon, the priest mentioned that it was the first funeral in his memory where the altar boys, all former patients, had actually volunteered their services because of their affection for the man.

What was out of synch during the funeral was the officiating priest mentioning the agony of my uncle's final days. It was startling to hear him say that Doctor Reggie had a wonderful life, but a horrible death. The priest had been with him the day before he died, in the best hospital in town, and had spent the better part of an hour hunting down a nurse to give a pain shot. "We can't," came the reply, "he's going to dialysis." This for a man obviously in his final hours.

So what we are left with is the memory of a wonderful man who was a great credit to a profession that, directly or indirectly, let him down in his final hours when he needed it most. This isolated vignette illustrates in a small way why a fringe player like Kevorkian has the staying power he has. We in the medical profession have done a great job with life... it's death and

the events leading up to its inevitability with which we've always had a problem.

Understandable, certainly. After all, death can seem like we have failed. But on the other hand death is a part of life, and it takes a discriminating judgment to separate failure from inevitability. We in the profession must stay connected with our patients, easing their final passage.

We can't fail the Doctor Reggies of the world in their final hour of need. ■

Doctor McCabe is MSMS president.

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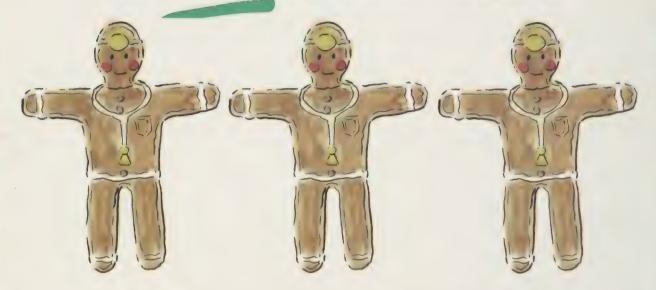
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MichiganMedicine

COVER STORY



Member needs drive MSMS: Physician groups a new focus

Today's medical environment sharply contrasts with that of 30 years ago. While physicians then operated primarily in a solo-practice setting, today's physician may be a member of a simple partnership, a member of a large corporation, or a solo practitioner. This member services issue of Michigan Medicine begins with our cover story on how MSMS is expanding its advocacy, education and service to meet needs of physician groups. You will find six groups profiled here, from their demographics to their philosophies, along with the MSMS member services they use. By Karen Bouffard

On the cover: Grand Rapids' Advantage Health Services officers, from left, Rose Ramirez, MD, Frank Letherby, and Douglas A. Edema, MD.

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From creation of the new MSMS subsidiary, Michigan Medical Advantage, to grassroots lobby organization to immunization education, MSMS anticipates and meets members' needs. By Sheri W. Greenhoe

New Group Insurance Trust product

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New MSMS members/employee insurance benefit provides economies and coverage By Cathy L. DeShano

Creating A Group Practice

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James Aluia, former group practice administrator, offers insight into establishing a successful physician organization.

Hospital Financial Information

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More help in using the first-ever MSMS compilation of Michigan hospital financial data for your personal planning and the benefit of your colleagues and communities By Dean Smith, PhD



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LETTERS

Michigan Blues linked to MSMS homepage

On behalf of the Michigan Blues, I want to thank the Society for hosting our Web page from July 1995 to July 1996. Though we have our own site now, the Blues remain supportive of the Society's site because we believe in the potential of the Internet for enhancing the practice of medicine as a profession and a business.

I invite you to visit our new World Wide Web site at your convenience. The address is www.bcbsm.com. Click on "physicians, hospitals and providers" for information of interest to you, and the other "buttons" (customers, media and community) for additional information. Our site has a link to the MSMS Web page so viewers can go right to it simply by clicking on the MSMS name. Our communications staff is refreshing our site constantly with new information and updates, so I suggest you check it out at least once every two weeks.

Our special thanks to MSMS's John Richards and Bill DeCourcy for their assistance in helping us maintain a Web presence before we developed our site.

Dexter W. Shurney, MD, Detroit

Vice President and Corporate Medical Director Blue Cross Blue Shield of Michigan

Medicaid studying ulcers

The Medical Services Administration Medicaid Drug Utilization Review program October 14 mailed targeted Michigan physicians letter regarding a new NSAID study. The study urges physicians to carefully evaluate patients receiving nonsteroidal anti-inflammatory drug therapy who are considered to be at high-risk for developing a NSAID induced ulcer. The study also outlines strategies to help decrease the risk for these ulcers. Physicians who are interested in obtaining information about this study may contact me at 517-335-5280.

Mary Sandusky, RPh, coordinator

Michigan Medicaid Drug Utilization Review program

Express your point of view in *Michigan Medicine*.

To submit a letter, mail, fax, or e-mail it to Michigan Medicine, 120 W. Saginaw St., East Lansing, MI 48823; fax (517) 337-2490; or e-mail jmarr@msms.org. Please type letters you submit for publication. Letters are published at the discretion of the editor and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Michigan State Medical Society.

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Editor Judith E. Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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William E. Madigan

Question:

••Who was your most memorable patient and why?

His last name was Kaza. He was the most concerned about his health and understanding about his disease. He survived for more than 20 years with his

condition. He listened to me very well and had excellent results. He was actively involved in his treatments. The problem with patients now is that they interfere with their treatment. Full cooperation and participation is the name of the game. This man made my job more rewarding."

Shawky A. Hassan, MD

Flint, Pediatric Allergy

A Mr. Phigpen was one of the first patients I had in medical school. He was a steelworker in South Chicago who had six kids and was 52-years-old. He was a big, strong guy who literally was an elder in church, a Boy Scout master and a Little League coach. He had a broken leg as a result of an auto accident. We had to put a rod in his femur. He developed blood clots in his leg and died as a result of pulmonary embolus. It was such a sad event for his family. It made me realize that people's lives are in our hands and that I wanted to do everything I could do to prevent such things from happening. This guy was full of a million jokes and always had a smile on his face. He reminded me of my dad."

Edward D. Lanigan, MDLansing, Plastic Surgery

A smiling, cherubic four-year-old girl, who despite the pricks and pokes she has received for allergic and immunologic dysfunction over the past three years, has amazed us with her cheer and good nature. Even through tears she will nod her head in acceptance, and often leaves us with a gift--a hug, delivered with her hand drawn picture of the day."

Karyn Gell, MD

Grand Rapids, Allergy & Immunology

I had a mid-60s lady who had numerous allergies; she was allergic to feathers, chickens and eggs. She was able to get by this when she went to have a chicken-like

dinner. She could eat roosters, but not chicken. So when she went to the meat department, she would ask them if they had any roosters. I could always envision the meat department saying, 'Here comes Mrs. Jones, get out your rooster-like appliances so we can fake it and sell her a chicken.'"

Joseph Kincaid, MD

Kalamazoo, Internal Medicine

When I was practicing as an internist in Fargo, ND, I had a patient who was so sick with a metastatic disease that nurses didn't want to touch him for fear his bones would break. He lived nine months longer than I expected him to. Several months after he died, the man's chaplain took me aside and told me he thought I should know why the man had lived so long. I learned he was afraid to die because he had accidentally committed a murder many years before and didn't want to go to hell. The man became a Catholic after the murder. He had arranged for two ceremonies when he died: one to be held in a church; the other, in his hometown, where he was buried in a private cemetery because he felt he would taint a sacred ground. It was a tremendous lesson for me in pain management. I got a lot of flack from people who wondered why I didn't just let the patient die. Sometimes it's not a matter of not letting your patients die, but that they choose to live."

David C. Engstrom, MD

Saginaw, Internal Medicine

BackTalk is a nonscientific sampling of Michigan physicians' opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to Michigan Medicine, BackTalk, PO Box 950, East Lansing, MI 48826-0950, or fax to (517) 337-2490, or e-mail jmarr@msms.org.

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Anti-Kickback Law: Leasing from Hospital

By Richard D. Weber, MSMS Legal Counsel

QUESTION: A local hospital is building a medical office building and recently offered to lease office space to physicians. No physicians agreed to lease space because the rent was guite expensive. The hospital then offered to reduce the rent by twenty-five percent (25%). If the reduced rent is below fair market value, would a physician violate the federal antikickback legislation by leasing the office space? Is it necessary to hire someone to determine the fair market rental value?

ANSWER: If the rent is below fair market value, there is a risk that the government could conclude that the lease is an unlawful inducement by the hospital for the referral of Medicare or Medicaid patients by the physician. In that event, both the hospital and physician would be exposed to liability under the anti-kickback legislation. Obtaining an appraisal is one way in which a physician can attempt to document compliance with the law and show that no inducement was involved in the lease agreement.

The Medicare Anti-Kickback Statute broadly prohibits referral or any arrangement for the provision of Medicare or Medicaid service in exchange for any type of "remuneration." "Remuneration" is broadly defined and includes any kickback, bribe or rebate. A person who knowingly and willfully solicits or receives any remuneration in exchange for arranging Medicare or Medicaid services is guilty of a felony. Civil penalties, including fines and exclusion from Medicare and Medicaid, may also be imposed.

Many legitimate business practices implicate the law even though there is no criminal intent. Consequently, the government has adopted various "safe harbors" which exempt some of these practices from liability. One safe harbor exempts lease arrangements if each of the following requirements are met:

- The lease is written and signed by the parties.
- The lease specifies the premises covered by the lease.
- The lease provides access to the premises on a periodic, sporadic or part-time basis, the lease specifies the exact schedule, length and charge for such intervals.
- The lease term is for at least one year.
- The total aggregate rental charge is fixed in advance, is consistent with fair market value in armslength transactions, and does not vary with the value or volume of Medicare/Medicaid referrals.

Under the safe harbor, "fair market value" is defined as the value of the

rental property for general commercial purposes without adjustment to reflect the additional value that one party (either the physician or hospital) might attribute to the property because of its proximity to sources of referrals.

An appraisal of the fair market rental value is not required by the safe harbor. By obtaining an appraisal, a physician can attempt to determine whether the proposed rent is consistent with fair market value, and if so, to document attempted compliance with the fair market value requirement. It should be kept in mind that while an appraisal is evidence of fair market value, it is not conclusive and the government could disagree with it. Nevertheless, reliance on an appraisal and compliance with the other safe harbor standards would certainly evidence a good faith intent to comply with the law.

Editor's Note: If you have legal questions you would like answered by MSMS legal counsel in this column, jot them down and send them to Judith Marr, Editor, P.O.Box950, East Lansing, MI 48826-0950.



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Quick connections

ISDN offers net-surfers speedy access at a cost

By William R. DeCourcy

ISDN (Integrated Services Digital Network) is a digital telephone line that can be used for carrying large amounts of computer data. This type of connection is becoming more popular for home and office Internet connections. An ISDN line is actually 2 lines, or channels, of 64 kilobaud (Kb) capacity, and one 16Kb channel. Baud is a term that describes the number of bits per sual teleconferencing.

Modems that operate between 2.4 Kb and 33.6 Kb are based on analog technology. These modems take the digital information coming from your computer and modulate it into an analog signal before sending it out over the plain-old-telephone (POTS) line. When analog signals are received from remote computers, they are demodulated

into digital signals. The term 'modem' is derived from this process (MOdulate DEModulate). Moving to ISDN phone service is analogous to switching from vinvl records to compact disks.

ISDN differs from a standard analog home phone connection in that there is a new type of switch in your telephone company's central office. An analog switch controls most telephone lines today. The digital switch employed in ISDN connections makes the

connection from your home to the device with which you are connecting completely digital. Because of this digital connection, a great deal more information can be transmitted on the copper wires running from your home or office.

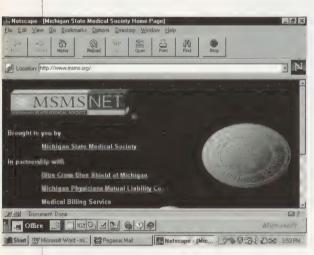
ISDN is available now and can be implemented in 2 steps. First, your local phone company must be contacted and ISDN availability researched. Most areas in Michigan are able to use ISDN, the determining factor being your distance from a telephone switching office. Pricing varies based on where you live, with typical phone company charges between \$35 and \$45 per month. In addition to the monthly charges, use charges may also be incurred depending on the number and types of calls you make. Ameritech local phone customers can visit their web site to obtain information specific to their calling area at http:// teamdata.aads.net/isdn/quote.htf.

The second step necessary to obtain ISDN service is to choose an Internet service provider that has ISDN capability. Voyager Information Networks, MSMS's partner in the MSMSNET project, currently has ISDN connectivity around the state. Their charges for dial-up access range from \$45 to \$75 per month.

Because ISDN Internet access is more expensive than traditional methods of accessing the Net, many users may choose to wait until the price lowers or other technologies are available. But for users who need the speed and convenience afforded by a high speed connection, ISDN is the way to go. ■

The author is chief of Internet Systems for MSMS.

"Surfing the Internet" is a monthly feature of Michigan Medicine. If you have a question regarding the Internet, the MSMS home page, MSMSNET, or Voyager Information Services, contact William R. DeCourcy at MSMS via E-mail at wdecourcy@msms.org or by phone at (517) 336-7575.



second transmitted by computers. These lines can be used together to provide 128Kb of data capacity, with a smaller channel left over for voice transmissions. Today's fastest analog modem technology allows for a maximum of 33.6Kb of data capacity. This capacity is rarely reached, however, as the analog line must be completely free of other signals to transmit data at this speed. Higher Internet data transmission speeds result in less time downloading World Wide Web graphics, and the ability to take advantage of emerging technologies, such as audio/vi-

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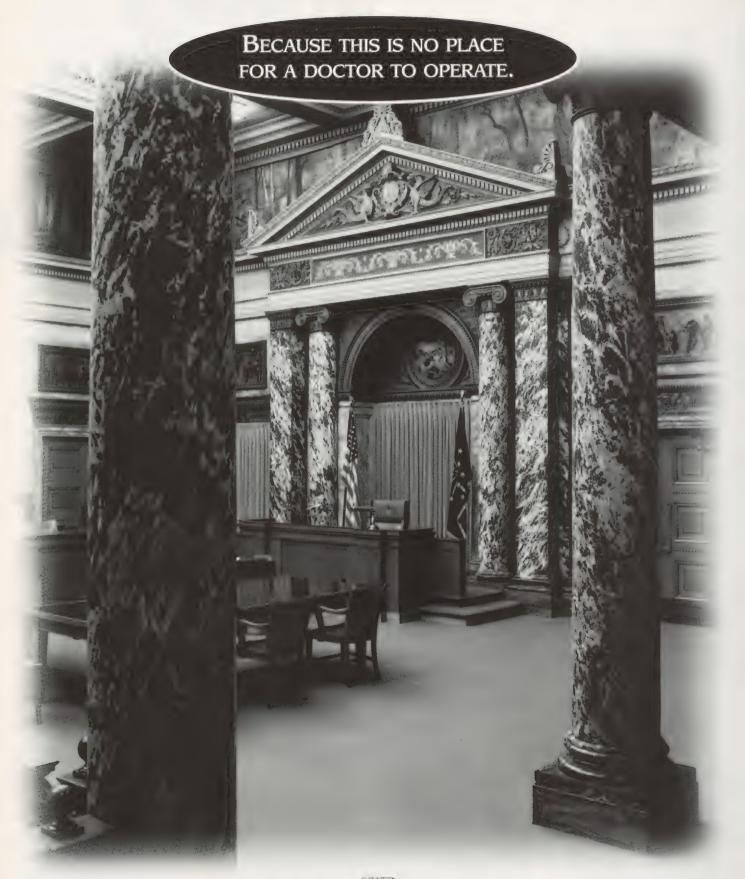
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MEMBER NEEDS DRIVE MSMS

Physician groups a new focus

oday's medical environment sharply contrasts with **1** that of 30 years ago. While physicians then operated primarily in a fee-for-service, solo-practice setting, today's physician may be a member of a simple partnership, a member of a large corporation, or a solo practitioner. As changes occur, so do physicians' needs. The following article describes how MSMS has stepped up to meet those changes and to guide physicians through the process.

Michigan physician groups

and the MSMS services they use

By Karen Bouffard

ccording to Petoskey family practitioner and MSMS Membership Chair Louis R. Zako, MD, MSMS has adapted perhaps better than any other state medical society to the changing medical marketblace.

"MSMS continues to provide traditional member services – such as excellent CME programs, cellular phone service and auto leasing—at extremely competitive prices. In recent years MSMS has also kept bace with the increasing complexity of the business side of medicine," Doctor Zako says.

As MSMS membership has evolved, MSMS has looked ahead to anticipate those members' needs and developed into a full-service organization. Where once solo practicioners were the basis for MSMS operations, the society now also keys products and services to groups of physicians. This article profiles some of those groups and the MSMS services they use.

"Solo physicians and small-to-large group practices have found MSMS activities in the PO/ PHO area extremely valuable," Doctor Zako adds. "More recently, MSMS is developing services for all of its membership, through Michigan Medical Advantage, the Society's MSO

(management services organization)."

"Increasingly, group practices as well as solo practitioners will find medical information systems, contract negotiation consultation stop-loss insurance for capitated plans and other MSMS services to be essential in order to provide care and to successfully compete in the managed care environment."

According to Dawn Reha, MSMS Manager of Member Services, solo practitioners and

small groups frequently rely on MSMS services because they lack the time, staff and expertise to adequately research all of the products they need.

"We've gone out and diligently researched everything that is out there in order to find the best that is available," Ms. Reha says. "Large groups," she adds, "often utilize the MSMS insurance plans, because we handle all the administrative aspects."

Here, Michigan Medicine profiles six groups that reflect not only the diversity of today's group practices, but the variation with which they utilize the resources of MSMS Member Services.

THE TRENDS

Orthopedic Surgery Associates, PC

Ypsilanti

PHYSICIANS: Eight orthopedic surgeons; one primary care/sports medicine physician

EMPLOYEES: 45

LOCATION: Two full-time offices in Ypsilanti and Plymouth: three time-share facilities at community hospitals in Chelsea, Livonia and Brighton **ORGANIZATION:** A professional corporation, with eight physician shareholders, this practice is home to the Institue for Preventive Sports Medicine. The Institue, non-profit organization. focuses on preventative sports medicine and its economic ramifications, according to David H. Janda, MD, director.

DID YOU KNOW?: Waldomar Roeser, MD, an Orthopedic Surgery Associates physician, also is the team physician for Eastern Michigan Uni-

PHILOSOPHY: "In this day and age of our changing healthcare environment, it's our philosophy that we'll keep all doors open. The



best route possible is not to lock yourself into one type of payment structure or patient group -- to have availability for all patients, no matter what their group or payment structure might be." -Doctor Janda

MSMS MEMBER SERVICES: BCBSM Individual Program

practitioners and small groups frequently rely on MSMS services because they lack the time. staff and expertise to adequately research all the products they need.

Solo

Michigan Heart, PC

Ann Arbor

PHYSICIANS: 29 Cardiologists

EMPLOYEES: 140

LOCATION: Nine locations, with full-time offices in Ann Arbor, Jackson, Livonia, Ypsilanti, Howell and Adrian. In addition, Michigan Heart timeshares part-time facilities in Livonia, Saline, Chelsea, Tecumseh and Plymouth. Its headquarters is at the Michigan Heart and Vascular Institute, located on the campus of St. Joseph Hospi-

ORGANIZATION: A professional corporation. Most decision-making is handled in weekly meetings of a six-member executive committee elected from the Board of Directors.

DID YOU KNOW?: Michigan Heart was one of the first four HCFA Coronary Artery Bypass Graph (CABG) Demonstration Project sites, and continues to participate in charging one global fee for Medicare patients.

PHILOSOPHY: "We're working towards developing appropriate criteria and clinical algorithms for all clinical procedures, and putting together a system for monitoring outcomes. In conjunc-



tion with that, we're committed to developing an information system that includes a clinical data base to facilitate capture of data needed for outcomes measurement." —Patrick I. White, **Executive Director**

MSMS MEMBER SERVICES: BCBSM Group Program; BCBSM Individual Program

Dennis Wahr, MD, member and former medical director of Michigan Heart & Vascular Institute (left) and Jane Bagchi, Executive Director.

Thoracic & Cardiovascular Institute, PC Lansina



PHYSICIANS: 18 Cardiologists, 5 Surgeons

EMPLOYEES: 140

LOCATION: Has 9 locations with offices in Lansing, Eaton Rapids, Charlotte, Carson City, St. Johns, Owasso, Mt. Pleasant and Grand Ledge. **ORGANIZATION:** Private Corporation which has

facilities at Michigan Capital Health Center. Medical/Professional Building, and at Sparrow Hospital South Annex Complex.

DID YOU KNOW? The various facilities contain specialized equipment for diagnoses, treatment and rehabilitation of cardiovascular and thoracic disease. Other locations are outpatient facilities for consultation and follow-up care, and serve local community hospitals.

PHILOSOPHY: "Our goal is to be `Value Providers.' committed to the highest patient satisfaction, at the lowest cost, with the best clinical outcomes." —Larry I. Johnson, Executive Direc-

MSMS MEMBER SERVICES: BCBSM Individual Program: Cellular One Communications: Disability Insurance

worked very hard to reduce the rate of C-Sec-

tion through VBAC. We're also utilizing vaginal

hysterectomy rather than abdominal hysterec-

Midland OBGYN Associates, PC Midland



tomy wherever possible, resulting in less recovery time and less time in the hospital for the patient." — Diane M. Bristol, Business Manager

MSMS MEMBER SERVICES: BCBSM Individual Program; MPMLC Insurance

Diane Bristol. Business Manager (left) and Marguerite Kuhn, MD, Midland, **OBGYN** Associates member.

Alonso Collar, MD.

Johnston, Executive

Director; and Daryl

Chief Executive

Officer: Larry

Melvin, MD.

(left to right)

Executive Vice-

President of TCI

PHYSICIANS: 4 Obstetrician-Gynecologists **EMPLOYEES: 13**

LOCATION: A full-time leased office, plus a fulltime leased space at the Community Hospital. The satellite is used by the on-call physician, who also sees routine patients there while on duty.

ORGANIZATION: A private corporation, with a Board of Directors consisting of the four part-

DID YOU KNOW? Among services the group provides are Colposcopy, LEEP, urodynamic testing, infertility and high risk pregnancy services. Also available through the group is the Abdominal Vaginal Vesicle Neck Suspension, a new, lessinvasive surgery for bladder repair in women.

PHILOSOPHY: "We are very concerned with risk management and cost containment. We've Ac vantage Health

Grand Rapids

PH/SICIANS: 65 physicians, in a primary-care group consisting of predominantly Family Practice. We also have OB/GYN, Internal Medicine. Pediatrics and Mental Health services.

EMPLOYEES: 380

LOCATION: 19 offices in the Grand Rapids and surrounding areas.

ORGANIZATION: Advantage Health is a Physician Hospital Organization (PHO) affiliated with St. Mary's Health Services/Mercy Health System. The Advantage Board is structured with 50 percent physicians and 50 percent administrative representatives.

DID YOU KNOW? In all, Advantage Health has MSMS MEMBER SERVICES: BCBSM Indi-85 healthcare providers, including 3 certified nuise practitioners, 2 geriatric nurse practitioner., 8 physician assistants, a nurse midwife and Inc.; Group MPMLC Insurance 6 mental health professionals.

PHILOSOPHY: "Our goal is to provide quality health care to improve the health status of the freelance writer.

people and families in our community." -Rose Ramirez, MD, President

vidual Program; Cellular One Communications; Delta Dental Program, IC System.

The author is a Williamston, Michigan-based

Hu ley Medical Group

PHYSICIANS: 50 physicians, 30 of which are in prir ary care.

EMILOYEES: 140-plus

LOCATION: Hurley Medical Center: 22 sites throughout Genessee County, 18 of which are prin ary care.

OR(ANIZATION: A private corporation which has a diverse mix of private practice physicians, specialists and hospital-based teaching faculty.

provide the medical center with a network of primary care physicians and specialists, who are out in the community providing services, and who can provide the first point of entry into the Hurley system. Our direction is to expand the number of primary care providers in the group. and to more fully integrate the group with our Physician-Hospital Organization (PHO)." —Rick Ward, COO

MSMS MEMBER SERVICES: BCBS: Delta Dental; MPMLC; Workers' Compensation; PHILOSOPHY: "The concept of the group is to Business Owners

More than an insuran provider

Deborah Zannoth, Chief of Membership Development, notes that services MSMS offers are not limited to insurance products. Among the additional services are MSMS' lobbying efforts which ensure members' viewpoints are heard at the State Capitol and in Washington DC: Medigram and Michigan Medicine, which keep members up-to-date on current issues and the Society's activities; and internet training, which familiarizes physicians with surfing the web.

"We work with legislators, as well as with regulators from the Michigan Department of Community Health, to provide a continuous liaison that ensures physicians' voices are heard," Ms. Zannoth says.

An important practical resource for physicians, she adds, is the MSMS Reimbursement Ombudsman, Joyce Nurenberg, who can "help groups untangle problems with third party payers" Ms. Zannoth says. MSMS also offers practice management assistance through James Aluia, Chief of Practice Management and Physician Organization, who provides services which "have gone so far as to manage practices for short periods of time during transitions between office managers," adds Ms. Zannoth.

Future plans for MSMS Member Services include adding a risk management specialist who will work with solo practitioners, small and large group practices to develop guidelines tailored to the unique characteristics of their practices.

From left: Rose Ramirez, MD. President of Advantage Health Physicians, PC: Frank Letherby, Vice President of Operations and Systems Inprovement: and Douglas A Edema MD. President and CEO.

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MSMS a full-service organization

By Sheri Greenhoe

he practice of medicine faces unprecedented challenges today. Physicians in all practice types are faced with opportunities and choices not even thought of just two or three years ago.

Given that, physicians understand that speaking with one unified voice is crucial. And they understand that anticipating and driving key developments is more important and more desirable than just reacting to them.

That's why MSMS membership is extremely valuable to physicians as the practice of medicine evolves into the next millennium. MSMS is both that unified voice and the most competent guide through uncharted territory. Armed with information and expertise, it is a personalized resource for physicians in all practice situations.

separately incorporated subsidiary that offers a full range of services to help physicians and physician groups manage their managed care con-

In addition, MSMS developed a first of its kind study of Michigan health plans, providing physicians and their patients with important information. And MSMS just completed an evaluation of Michigan hospital financial data, giving physicians a new and important decisionmaking tool.



personalized resource for physicians in all practice situations.

MSMS is a



Putting new ideas to work

MSMS always is among the first to analyze new concepts and put them to work. It published ground-breaking studies on Physician Organizations, as well as Management Services Organizations, then promptly developed cutting edge services to members at the direction of physician leaders. Michigan Medical Advantage, the new MSMS management services organization, is a

Strategies that work

MSMS has a proven track record of creating working strategies for the changing environment. The society recognizes and understands the fundamental and dynamic changes taking place right now. To assist physicians, MSMS has a team of experienced consultants who can assist physicians in any practice type with the business side of medicine, including practice management issues and risk management.

MSMS offers ombudsman assistance with regulatory agencies and third party payers. They answer questions concerning CLIA regulations, the Americans with Disabilities Act, Workers' Compensation and Stark II. Our reimbursement ombudsman has cut through mounds of red tape to resolve hundreds of members' problems with third party payers.

MSMS has created the only source physicians need for information vital to their practices, including e-mail and unlimited access to the Internet. It's called MSMSNET, and it is the physician's easy to use on-ramp to the information superhighway. It's a convenient place to find MSMS news and information, conference registration and links to important websites of interest to doctors. Check it out at http:// www.msms.org/.

Providing education opportunities for physicians continues to be an important MSMS service. MSMS conducts a number of conferences each year on the economics of medicine and on clinical topics. MSMS presents the Annual and Regional Scientific Meetings, the Maternal and Perinatal Health Conference, and other quality opportunities for physicians to earn CME credit.



Advocacy for patients

Patient advocacy is a priority, and MSMS has information for physicians and patients regarding the legal scope of durable power of attorney, options for the terminally ill and the issue of physician assisted suicide, AIDS and Immunizations speakers bureaus, and a variety of materials regarding family violence.

MSMS represents physicians on the wide variety of health care issues discussed by the legislature during the year, and works directly with the many regulatory agencies which affect health

care. MSMS also is busy ensuring that physician voices are heard on health care reform and antitrust issues at the national level as well.



Special programs

Of course, MSMS provides a wide range of insurance programs specifically designed for physicians, their families and their employees. MSMS' Group Insurance Trust makes available new Capitation Stop-Loss insurance, BCBSM health insurance, Delta Dental insurance, and Auto Owners home and auto insurance through the MSMS insurance administrator, Stratton Cheeseman and Walsh.

Physician Service Group is a fully owned subsidiary of MSMS which provides auto leasing and cellular phone services, medical billing services, medical equipment leasing services, and a host of other programs for physicians' practice needs and lifestyle.

MSMS is here to help

Have a question, or want further information? Contact MSMS by phone, fax, e-mail or US mail. Call MSMS at (517)337-1351; send faxes to (517)337-2490; send e-mail to msms@msms.org; or send mail to PO Box 950, East Lansing, MI 48826-0950. ■

The author is MSMS communication manager.

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service.

— Jaak M. Pahn, MD Sault Ste. Marie

When it comes to the right coverage, you can count on Michigan State Medical Society to anticipate your needs. Trust us to keep you informed and covered. Contact an MSMS Group Insurance Trust representative today to review your coverage. Call toll-free (800) 748-0195, fax us at (517) 337-2590, or send E-mail to msms@msms.org

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Michigan State Medical Society
GROUP INSURANCE TRUST

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New Group Insurance Trust product

MSMS members have another high-quality, low-cost option

By Cathy L. DeShano

new health care plan customized to meet physicians' needs is available to MSMS members through the MSMS Group Insurance Trust.

Blue Cross/Blue Shield of Michigan designed Community Blue PPO, the new GIT offering, after taking years of comments from physicians and people who described their needs in a health plan, according to Dawn Reha, Manager, Member Services for MSMS. The plan, available to MSMS members during November open enrollment, offers freedom of choice in selecting physicians, while keeping health care costs low and quality of care high.

Unlike plans which require individuals to choose a primary care physician, Community Blue PPO has no such "gatekeeper," according to Ms. Reha. Instead, Community Blue PPO allows its members to choose from among 12,000 physicians and 153 acute care hospitals participating with the PPO in Michigan, options which make it "like money in the bank" to use, said Ms. Reha.

People who stick to these "in-house" physicians will have advantages including small, fixed copays for office visits; pre-and post-natal visits covered at 100 percent; and emergency and urgent-care treatment copays waived for accidental injuries and hospital admissions.

The plan provides two features which make it stand out from many counterparts: preventive care benefits and reduced paperwork. Community Blue PPO grants its consumers of all ages one annual physical per person, annual gynecological exams, well-baby/child care, childhood immunizations up to age 15, pap smear screening, proctoscopic exams, fecal occult blood screening and prostate specific antigen screening. People who have grown tired of completing Master Medical forms each time they see a physician will be relieved to know their providers will now complete all forms.

Because the plan focuses on attending a BCBS

preferred provider physician, benefit stipulations apply when Community Blue members see out-of-network physicians. While most services are covered

100 percent when members visit an in-network physician, only some are covered, and co-pays and deductibles may apply, when patients seek service from an outside physician. Preventive care visits, child immunizations and routine pap smears are among those services not covered when attending an out-of-network physician. However, unlike some plans, Community Blue allows out-of-network cost-sharing amounts to apply to in-network cost-sharing requirements.

Beginning in 1997, cost-sharing benefits and riders will apply to the new plan to reduce costs, already at just 83 percent of a traditional plan. However, only those who have joined Community Blue as part of a group will have the option to add riders.

For more details on the new MSMS insurance plan, contact Ms. Reha at MSMS, 517-336-7571, or 1-800-748-0195, or email her at dreha@ msms.org.

The author is Michigan Medicine editorial assistant.

Unlike plans which require individuals to choose a primary care physician, Community Blue PPO has no such "gatekeeper."

Creating a group practice?

Strategic planning can prevent future problems

A Michigan physicians have moved to forming group practices, MSMS has worked in a variety of ways to assist them. For instance, MSMS has contracted with some newly-forming groups to provide administrative services and even the administrators. James J. Aluia, senior consultant to Michigan Medical Advantage, and MSMS chief, physician networks and practice management, has served as administrator for newly-forming physician groups in the state and has learned a great deal about what it takes to organize a group. In this article, Michigan Medicine asks Jim what he's learned. His answers may benefit all physician groups.

Q: Over the past year, you have worked as an administrator in a multi-specialty practice that was newly formed. Could you tell us the key lessons which you learned from that experience?

A: I think there were many lessons learned. One of them is that there needs to be a tremendous amount of communication among physicians as they consolidate because they are used to having full autonomy in their practices. They are used to making all of the decisions in the practice—big, small, strategic planning types of decision.

As they begin to consolidate their practices and one or more of them begins to take the leadership role, some physicians are left out of the loop. Without effective communication, there begin to be upset feelings. Whether or not the decision is right or wrong, physicians tend to be upset by the direction of the decisions.

In some cases, it is not the way you get to the end point that physicians are as concerned about, but the means that you use to get there. The process has to be one that has a tremendous amount of communication, at least initially. I think once all the physicians feel more

comfortable and trust builds, you can begin to back off the total communication effort.

Q: So, in essence, physicians who are used to running the show have to delegate responsibility, and key leaders need to keep everyone informed. How do they do that effectively?

A: Physicians may rely on board meetings, which are fairly regular. But even in the board meetings, not all of the decisions and the directions of the practice are revealed.

Q: You mean things go on behind the scenes, little

conversations?

A: More of the details. Adjustments and details of the accounting systems, adjustments in physician compensation systems may be made for purposes of finalizing contract decisions between the leaders and whatever service organization working with the group are made.

Q: You are suggesting there are things that leaders do on a day-to-day basis between board meetings?

A: More of the directional or strategic type issues come up at the board meetings, which may not be as important to all the physicians in the board as the detail issues. The day-to-day issues really don't get recognized at the board meetings, but they have a lot of power in determining whether or not the leader is an effective leader. Like a lot of decisions, some of the movements in those decisions can be looked at as either positive or negative by the other physicians, and those issues begin to be real trust issues in the long run.

Q: So what were some of the special challenges, in addition to communication, that your group faced, and what lessons can we learn from them?

Physicians should undertake a strategic planning process before the merger actually occurs.

A: I think some of the problems resulted from the fact that the physicians waited until the group was actually formed to hire an administrative type person. The administrative person, thus, had a lot of catching up to do in terms of understanding the dynamics of the group, understanding who was coming from where, what each physician brought to the practice, which physicians had which employees that they brought to the group practice. In addition, several of the physicians still practiced at other sites so there were employees at other sites. Before they actually merged, the physicians did no talking about merging employees, so after the fact, we had to reconcile the differences in employee benefits.

Q: So those issues, you're suggesting, should have been handled before the merger.

A: Yes. Physicians should undertake a strategic planning process before the merger actually occurs. MSMS offers this service. It's done through a series of meetings where details in human resources are gone through specifically. We look at all the practices that are merging. We then move toward a human resource plan that all of the consolidating physicians can live with. The plan addresses all major issues, including the number of holidays, vacation time, sick time and all other benefits so that even prior to the merger, these things can be shared with the employees. Also during this time, we go through the governance structure and then we go through the compensation structure so that there are detailed written plans on all of these issues and there are no surprises or disappointments.

Q: What are the governance issues?

A: Strategically you really have to develop a plan that lets you know what's going to happen in the organization. By that I mean that if you think this organization is going to grow, then you've got to develop a strategic plan to allow other physicians into your group.

Q: So you're planning ahead, not just for this immediate merger, but for other physicians to join in the future? A: Right. Then you have to determine how these new physicians will be included—are they going to be board members? Are they going to be partners eventually? Is it going to be two years before their partnership begins and then how are they going to be able to buy into that partnership? And at that point are they a full partner in the practice or are they a partial partner? If they're a partner are they allowed on the board? Those issues need to be defined and written down up front.

Q: So the three big issues in strategic planning are governance, compensation and benefits?

A: I would call it more the employee human resources package.

Q: Why is it advantageous for physicians to utilize a facilitator to assist them in strategic planning?

A: A facilitator will bring out and talk about these details. Not all physicians recognize what they are getting into in a joint venture or merger of consolidation. A facilitator can serve as both the listener and the scribe.

Q: A neutral party with no vested interest. This person should be more experienced from having gone through several group formations.

A: Well, I think physicians, especially formerly autonomous physicians, need to have flexibility and need to recognize that in order to make a group successful, they are going to have to give up some autonomy and the idea that they must be in on every decision as the group moves forward.

Q: Why shouldn't they be involved with every decision?

A: This becomes unwieldy, unmanageable. If you are going to move any process or business along, if you entrust in leaders to make those decisions and to move things, then you can't have votes on everything. As an owner of the business you need to know when and how to make your points and how to really begin to manage the total system and not manage every detail in the system.

A part of the planning process should be to determine whether or not to plan through decisions of consensus or decisions of the strongest voice.

If you think
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other
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into your
group.

Q: Any other keys to a successful group practice?

A: I think you have to really determine your partners up front. A part of the planning process should be to determine whether or not to plan through decisions of consensus or decisions of the strongest voice. You, as a physician owner, have to determine if these are the partners which whom you can really get along. You should get to know your partners' business acumen, and hear his or her ideas and concepts.

Q: What are the benefits, in your mind, of a group practice versus solo practice?

A: As more and more managed care comes into the market place, I think bigger group practices are going to be more of a security for physicians. I think the group practices are going to be better able to coordinate some of the patient care than are single practices. I think group practices will better afford some of the information and data systems necessary to

control patient volumes and to control the economics of that population base.

Q: Are economies of scale an issue too?

A: Certainly. For instance, purchasing and owning a single billing system or leasing a billing system is a tremendous benefit of a group. You can eliminate all of the payroll and most of the single human resources problems that a solo practitioner may have. If Susie doesn't come in today, he's on the phone trying to find an extra person.

Q: How will group practices affect expenses?

A: Certainly the largest expense is going to be the expense of your employees. I have always found that the better you treat your employees and the better quality person you have, the fewer fundamental problems that you are going to have as a manager, as an owner of a business. Sometimes physicians get in a trap and want to decrease their payroll expense so they hire less-qualified people. That poses a problem in the long run.

Access to Food Constitutes a Human Right



World hunger is an ever-present scourge that claims 35,000 lives each day.

Access to food constitutes a human right. In 1976, the United States Congress passed a Right to Food Resolution which declared the sense of the congress to be "that all people have a right to a

nutritionally adequate diet".

Physicians Against World Hunger (PAWH), a non-profit, taxexempt organization was founded so that physicians could collectively defend this human right by raising funds to support well-recognized, reputable organizations that are directly engaged in working with the poor primarily for the purpose of ending death by starvation.

Please join us—together physicians must help bring an end to world hunger.



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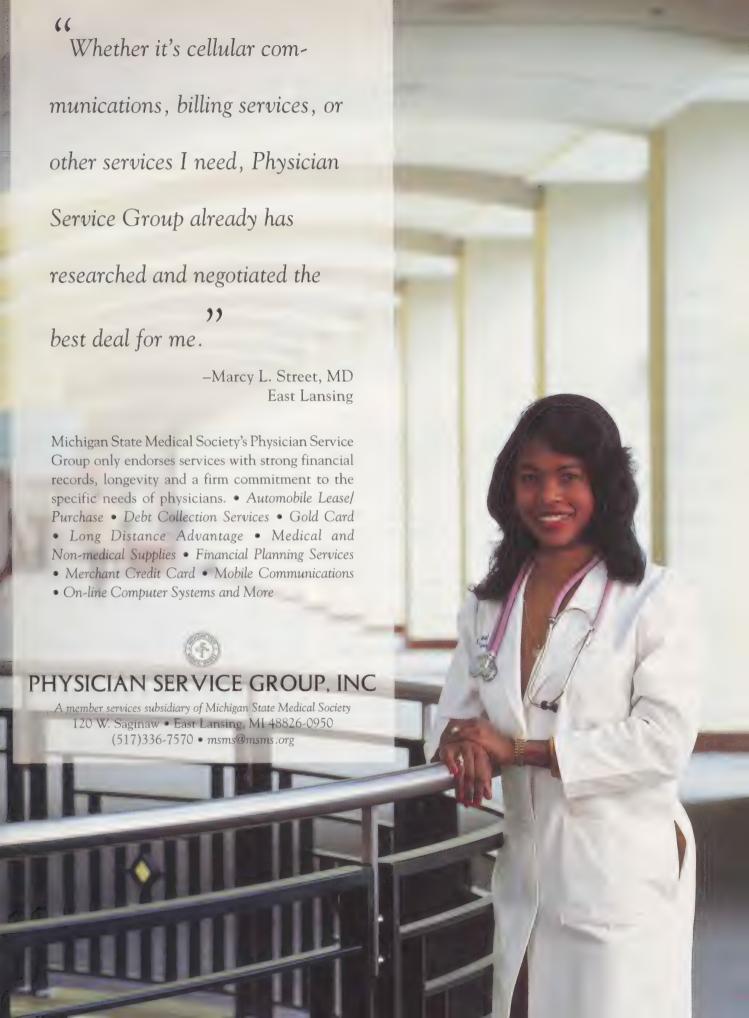
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Does your hospital fit your future?

MSMS hospital financial information makes for good partnerships

By Dean G. Smith. PhD

Hospitals' relationships with other organizations, contracts with payers, quality of care provided and other strategic information ... may be the most important indicators of future viability.

here is a growing interest among physicians in working with hospitals hospital organizations, integrated delivery systems and other arrangements for managed care contracting. As we know from partnerships of all types, the more you know about your partner, the more efficient and effective the relationshib.

Sharing information on finances provides physicians and administrators with a good foundation for building on their relationships. As highlighted in Medigram and Michigan Medicine, the Michigan State Medical Society this month disseminates the results of its Hospital Financial Information in Brief project. The results of this project will further physicians' understanding of hospital finance and facilitate discussions between physicians and administrators on their collective future.

The MSMS Hospital Financial Information in Brief project provides balance sheets, income statements and a variety of financial indicators.

Balance sheets

Balance sheets provide a picture of a hospital's holdings and how they are supported. The two parts of the balance sheet (that must balance one another) are assets on one side and debts and fund balances on the other. "Fund balance" is a term that has special meaning in hospital finance that does not match its meaning in everyday use. Fund balances indicate the differences between the assets held by the hospital and its debts. For example, if the hospital owns an asset purchased for \$100 and it has \$50 in debts, then its fund balance is \$50. Many persons confuse fund balances with reserves. Fund balances are not reserves. Reserves are cash, marketable securities or other assets held for future needs. Part of the confusion over the term "fund balance" is to be expected. Apart from the general fund, many hospitals have special purpose funds or board designated funds. These other funds may be associated with charity care, replacement expansion or other needs. These other funds may also be "balanced" by assets that are being held aside for the fund's special purpose. The important aspect to note is that lines on

balance sheets labeled cash or marketable securities, not lines labeled fund balances, give an indication of a hospital's potential reserves.

Income statements

Income statements provide a picture of a hospital's earnings for the year. Hospitals' income statements are like the income statements for most physician practices with a few notable differences. One difference is that hospitals use "accrual" accounting rather than "cash" accounting. This means that revenues and expenses are recorded when services are provided (accrued) rather than when money is actually received or spent. Given delays in payments, hospitals may earn income, but still have no "money" available for expenditures. Another difference is the myriad of special rules that accompany reporting of income statements to Medicare. Data for Hospital Financial Information in Brief come from Medicare Cost Reports that follow a standardized format that does not necessarily provide a complete picture of a particular hospital's financial status.

Financial indicators

More than a dozen indicators are also presented in the reports to help interpret the financial statements. A couple of important indicators are presented here. Average Age of Plant is an indicator of the physical structure of a hospital based on its depreciation expenses. For example, if a hospital's physical plant has an expected life of twenty years and it records 1/20

of its value as a depreciation expense each year, after ten years the Average Age of Plant would be ten years old. (This is not rocket science.) Reality is that hospitals are continuously adding, improving and renovating facilities, making Average Age of Plant less precise than in this simple example. Still, having an average age of assets of twelve or more years generally reflects an aging facility in need of renovation.

Days Cash on Hand is an indicator of a hospital's ability to pay its bills and make the dayto-day purchases required to maintain a facility. Days Cash on Hand is measured by dividing cash and securities by average expenses per day. Generally, hospitals seek to maintain sixty or more days of cash on hand for payment of current bills, and twice that much as a cushion against late payments from third parties and to make strategic investments.

Return on Assets (ROA) is an indicator of hospital profitability and viability. ROA is measured by dividing net income by total assets. While a hospital may be not-for-profit, that does not mean that it can exist without making profit. Hospitals require a ROA of four to five percent merely to maintain existing assets. An average hospital will require ROA of six percent or more in order to keep pace with technological changes in health care delivery.

Measurement and interpretation

More sophisticated financial analysis is required to get a complete picture of the financial status of a hospital. Just using the above three indicators, one can see that maintaining an acceptable physical plant means having a low Average Age of Plant, which requires having enough cash on hand to pay bills and invest strategically, which requires earning an acceptable return on assets. There are complex issues of measurement and interpretation for many indicators, making comparisons among hospitals difficult. General definitions and data on these and other indicators will be available in the MSMS Hospital Financial Information in Brief. For specific information on how your hospital computes any of these indicators and what levels of Average Age of Plant, Days Cash on Hand and ROA are required for success, you should engage in discussion with administrators —which is an objective of the project, to put physicians in a position to engage in informed discussions with administrators.

In addition to the strictly financial measures

presented in balance sheets and income statements, there are a number of other indicators of the health of a hospital. Hospitals' relationships with other organizations, contracts with payers, quality of care provided and other strategic information do not fit neatly into tables of numbers, but may be the most important indicators of future viability.

Hospitals in Michigan are predominantly community hospitals, meaning that the ownership and responsibility for the hospital resides in the community, of which physicians are important members. Physicians won't become experts in hospital finance through reading these reports. However, it is expected that physicians will become more sophisticated consumers of financial information, and better prepared to be good community members and effective business partners with their hospitals.

Doctor Smith is an associate professor, Department of Health Management and Policy, University of Michigan School of Public Health.

What you can do with new hospital financials

With MSMS release of its first-ever compilation of Michigan hospitals' financial data, physicians may now analyze and interpret the data to their own benefit, and that of their colleagues', hospitals' and communities' financial futures. MSMS suggests that members:

- 1) Personally analyze their own hospital's viability
- Meet with hospital administrators.
- Schedule hospital staff and county medical society meetings.

MSMS already has scheduled county medical society meetings in Lenawee, February 25, 1997; Jackson, March 18, 1997; Kent, May 13, 1997, and Ottawa, September 9, 1997. Additional presentations are in the works with Calhoun, Kalamazoo and Genesee county medical societies.

Call on MSMS staff for expertise and help in the above steps. Contact F. B. "Tom" Plasman at MSMS, 517/336-5724, or email him at tplasman@msms.org.

That is an objective of the project - to put physicians in a position to engage in informed discussions with administrators.



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Donating to medical education

Give money to your medical school of choice

By Linda Allen

s the holiday season and the end of the tax year approach us, our thoughts naturally turn to supporting charitable organizations. MSMS Alliance members encourage you to consider a donation to your favorite medical school through the American Medical Association Education and Research Foundation (AMA-ERF).

The AMA-ERF has been in existence in one form or another since the 1950s. From its modest beginnings, AMA-ERF has consistently supported quality medical education in the United States. The track record is impressive: \$63 million contributed to the nation's medical schools in 40 years, nearly \$10 million in the last five years alone. Contributions average \$2 million yearly, a visible sign of the physician community's continuing commitment to excellence.

The success of the Medical Alliance/Auxiliary fund raising hinges on two important features which make AMA-ERF unique: 100 percent of the contributions given are to medical schools (nothing is deducted for administrative costs). and the contributor decided which medical school will receive the contribution. Contributors may choose how they want their contributions to be used - to support school programs or medical students. As a bonus, because AMA-ERF is a non-profit organization, all contributions are tax deductible.

The oldest and largest of the AMA-ERF funds, the Medical School Excellence Fund, has provided \$47 million to medical schools since 1957. In 1955, this fund received nearly \$450,000 in contributions. Contributions to the Medical School Excellence Fund provide grants to medical schools to use where the schools need them most -- special student programs, research projects, guest lectures, attendance at conferences and meetings, new equipment, books and other publications, and building improvements.

Medical Student Assistance Fund, begun in 1983. provides funds for student loans, grants and scholarships. In 1995, this fund received more than \$1.2 million. In addition, the AMA-ERF Development Fund supports pilot and experimental programs in health and medicine and the Categorical Fund

supports specific research areas.

During the May 1996 annual meeting of the MSMS Alliance, AMA-ERF distributed funds to Michigan medical schools as follows:

Michigan State University: \$10,119.03 Wayne State University: \$21,047.86 University of Michigan: \$23,869.32

For information on how to contribute to AMA-ERF, please address your correspondence to me as follows:

Linda Allen 2006 Springwood Dr Midland, MI 48640

(517) 835-9809 email: jladalen@cris.com

The author is AMA-ERF Chair for the MSMS Alliance.



Linda Allen

Update on AIDS Provider Education

Speakers Bureau Continues to Get More Requests

by Tom Seely

The Michigan State Medical Society AIDS Provider Education Project and Speakers Bureau has been providing timely HIV/AIDS prevention and treatment information to health care providers in Michigan since 1987.

Open Letter from Doctor Saravolatz

AIDS is the leading cause of death among men 25-44 years of age in the United States. This fact is alarming as it should be to all health care providers. Unfortunately, as in other epidemics of infectious diseases, the Human Immunodeficiency Virus and its progression to AIDS has a predilection for economically disadvantaged populations who have less knowledge about HIV transmission and prevention strategies.



Louis D. Saravolatz, MD

In addition, HIV/AIDS is increasing more rapidly in the heterosexual population than in any other risk group. Women and teenagers are at risk, but have often not recognized the threat of HIV.

HIV already has infected over one million Americans and affected many more. Activities in research and treatment are occurring at a strong pace. This is encouraging to researchers and educators. Unfortunately, the goals of education and prevention strategies are still not achieved. We must provide our patients and citizens in the state of Michigan with accurate information dealing with HIV/AIDS and how to protect themselves.

Sincerely.

Louis D. Saravolatz, MD, Chair MSMS AIDS Provider Education Project Chief, Department of Internal Medicine St. John Hospital The Project and Speakers Bureau continues to stick to its mission of fulfilling requests for literally hundreds of speakers each year. The Speakers Bureau consists of over 150 physicians, nurse practitioners, social workers, HIV test counselors, attorneys and persons living with HIV/AIDS. The need for these speakers continues to increase. In fact, during 1995 and 1996 the Bureau has averaged about 300 requests for HIV/AIDS speakers

In addition to the Speakers Bureau services, the MSMS AIDS Provider Education Project also maintains a video and slide library to assist speakers with presentations. Topics available on slide include universal precautions and infection control techniques, HIV prevention and transmission information, and pediatric AIDS and HIV in women.

Also available are less technical videotapes that often are used to help educate community groups, churches, schools, and other non-medical audiences.

If you would like more information about the MSMS AIDS Provider Education Project, please contact Tom Seely, Coordinator, at 517-336-5770. If you would like assistance in arranging for a speaker, please call Bonnie McCauley at 517-336-5772.

Tom Seely is coordinator of the MSMS AIDS Provider Education Project

The Michigan AIDS Fraud Task Force was founded in 1990. The Task Force members are representatives from local community AIDS education and service organizations, state and local health departments, professional health organizations, and the Food and Drug Administration. The primary purpose of the Task Force is to help educate people about the dangers of AIDS fraud.

Health care fraud in general is a serious problem. No part of the health care system is free of fraud -- not suppliers, insurers, home health care or even physicians. Specifically, AIDS fraud is promotion of an AIDS-related health product, treatment or service known to be false or labeled with unsupported claims. Fraud can include, but is not limited to treatment, nutrition, mechanical devices, burial fees, drugs, supplements, etc. Victims of fraud may include not only people with HIV/AIDS, but partners, family and friends as well.

Don't be fooled. Avoid AIDS fraud. Be suspicious of any claim that a product or treatment can prevent or cure HIV/ AIDS or will have a "miraculous effect:" that claim is false. If you are looking for treatments for AIDS or HIV infection, protect yourself. You should question any treatment that:

- is promoted as "miraculous", "foolproof", "secret", or "suppressed".
- claims to boost or enhance your immune sustem.
- · claims to have been discovered by a foreian doctor and/or is advertised as "tested in another country." All drugs and medical devices to treat HIV/AIDS must be tested and approved for use in the United States before being sold.
- is sold to cure or prevent other illnesses such as cancer in addition to HIV/AIDS.
- is an experimental drug treatment that

- you have to pay for. It is very rare for patients to be charged for experimental treatments or drugs. It is illegal to make profits from experimental drugs.
- uses personal success stories to sell the product. Personal success stories are not proof that a product or treatment works.

It is always a good idea to let your health care provider know exactly what treatments you are taking, like vitamins or herbs, even when those products don't specifically claim to treat HIV/AIDS. Your doctor should be a partner in your health care.

If you know or suspect a business or person is selling or advertising fraudulent health products or services, you can help stop them and protect others by reporting it. You can report fraud by calling or writing to: U.S. Food and Drug Administration, 1560 E. Jefferson, Detroit, MI 48207, phone: 313-226-6260.

Check out the MSMS AIDS Provider Education Project/Speakers Bureau Home Page

In September, 1996, the MSMS AIDS Provider Education Project and Speakers Bureau launched a home page on the Internet. Included is information on how to join the MSMS HIV/AIDS Speakers Bureau, how to schedule a speaker, upcoming presentations, and profiles of a few of our speakers. There also is a link to other HIV/AIDS resources. The Internet address is www.msms.org/resource/ hivsb.htm. Come check us out.

Pregnant Women and HIV

By James K. Haveman, Jr.

In the United States, AIDS is the fourth leading cause of death among women 25-44 years of age, and the seventh leading cause of death in children 1-4 years of age. Transmission from infected mothers to infants around the time of birth accounts for the clear majority of HIV infections in children.

Since July of 1988, the Michigan Department of Community Health has con-

Clearly, a statistically significant downward trend has been observed in overall statewide HIV seroprevalence and Detroit Metropolitan seroprevalence rates.

These declines may represent the first indication of the success of HIV prevention efforts.

ducted a survey based on Centers for Disease Control and Prevention protocols to determine maternal HIV antibody prevalence. The Survey of Childbearing Women utilizes blood samples from specimens collected for statewide neonatal metabolic screening on all infants born in Michigan hospitals.

As of July 1995, a total of 907,185 specimens were included in the survey and 556 tested positive. This represents an HIV seroprevalence rate of 6.1, or about six HIV infected mothers per 10,000 live hospital births. Clearly, a statistically significant downward trend has been observed in overall statewide HIV seroprevalence and Detroit Metropolitan seroprevalence rates. These declines may represent the first indication of the success of HIV prevention efforts.

We have established the Subcommittee on Perinatal HIV Reduction—a subcommittee of the Maternal and Child Health Advisory Committee. The subcommittee consists of providers (including several members of the Michigan State Medical Society), consumers, women and their families and minority populations affected by HIV, and community-based organizations. The recommendations from this subcommittee will include a plan for assuring universal counseling and voluntary HIV testing for all pregnant women in Michigan. Counseling and testing are important because HIV-positive pregnant women can reduce the risk of infecting their infants by being treated with zidovudine (AZT) during pregnancy.

Practitioners play a vital role in influencing patients to be tested. And it is indeed vital that we urge pregnant women to seek counseling and to get tested for HIV. By receiving the care they need, women not only improve their chances for a healthier pregnancy, but they also reduce the likelihood of transmitting this dreaded infection to their newborns.

The author is director of the Michigan Department of Community Health.

WHERE TO CALL:

Michigan AIDS hotline:

(800) 872-2437

Information in Spanish:

(800) 826-7432

Teen hotline:

(800) 750-8336

TDD line:

(800) 332-0849

Health Care Providers:

(800) 522-0399

Provided by the Michigan State Medical Society

National AIDS hotline:

(800) 342-2437

Spanish -- (800) 344-7432

National AIDS Clearinghouse:

(800) 458-5231

Clinical trials

(National Institute of Allergy and Infectious Diseases):

(800) 874-2572

HIV/AIDS treatment

(800) 448-0440

Michigan HIV/AIDS Facts

- Michigan ranks 15th among U.S. states, the District of Columbia and territories in total cases reported as of January 1, 1996.
- Michigan's annual rate of persons contracting AIDS as of January 1, 1996, was 31st in the U.S. and territories.
- It is estimated that 8,500 11,500 Michigan residents are infected with HIV.
- The statewide Survey of Childbearing Women shows that in 1994, 65 Michigan births were to HIV-infected mothers, a decrease from an approximate average of 80 births between 1991-1993.

(Source: Michigan HIV Report)

Back with the Blues

Physician fans will find rock artists returning to origins

By Roy S. Goodman, MD

Healey sounds great on the 1995 "Cover to Cover" because the blues is a guitarist's music. ou're never too old to rock and roll if you're too young to die."

—Ian Anderson

The blues is like a bicycle. The basic patterns have been around forever; a century-old bike looks remarkably like a brand-new one, and the few 12-bar variations haven't changed since the field hands who had migrated to Chicago factories codified them in after-hours joints in the 1950s. The designs are so durable because they're so effective; the classic double-diamond works for everything from Junior's Huffy to Lance Armstrong's Caloi, and the classic 12-bar blues works for everything from "Surfing USA" to the most downtrodden slow blues.

Most rock has its roots in the blues, and lately a number of artists have been returning to those roots. In most cases, it's the smartest thing they could have done.

When Jeff Healey released his "See the Light" CD in 1988, the song "Confidence Man" fairly burst out of the radio. Healey got a lot of publicity because he's blind and he plays in a bizarre overhand style, but it's more important that he's a great guitarist and a pretty good singer. Unfortunately, Healey was to prove on that CD that he isn't a great songwriter. The "Hell to Pay" CD had only one memorable song on it, and that

was written by Mark Knopfler. With the 1995 "Cover to Cover" CD, Healey finally had the sense to stop writing his own material. And of the material that he did cover, more than half is blues. At last there's a CD that properly showcases Healey's virtuosity--and you've never heard a high-powered off-the-wall arrangement of the classic "Dust My Broom" riff like the one in "Highway 49."

Healey sounds great on "Cover to Cover" because, as Robin Trower explained roughly twenty years ago, "the blues is a guitarist's music." Trower's own music has always been deeply rooted in the blues, but it wasn't until 1994 that he released a CD on which most of the music was straightforward blues (or about as straightforward as Trower's ornate, fascinating backing arrangements allow.) The "20th Century Blues" CD harks back to his classic early albums. "Bands of the era [the 1970s] sued to boast of their 'power' or 'energy," I wrote back in 1982 "The Trower band had strength." Now they have it again. Bassist Livingstone Brown is a little more adventurous than James Dewar, but he provides



Roy S. Goodman, MD

a very similar voice to match an essential ingredient of the early Trower sound. Just as he did on his masterful arrangement of "Rock Me Baby," Trower—master of multi-tracking—plays some of the songs here with only one guitar. Savoy Brown has been around, with numerous personnel changes, for nearly thirty years now. Guitarist Kim Simmonds learned on the job and quickly evolved into one of the best blues guitarists ever. The old "Blue Matter" and "Looking In" albums are classics of the genre, and fortunately they've transferred well to CD. But early in the 1970s, Simmonds inexplicably decided that Savoy Brown was a rock band. It wasn't, and they proceeded to prove that with a string of eminently forgettable albums. Then, in 1992, they released "Let it Ride." It's not all blues, but at least Simmonds finally had the sense to realize that blues is what he plays best, and blues is what sounds best on this CD. The 1995 "Bring it Home" is even better and even more bluesoriented.

Savoy Brown helped originate the British Blues sound, but they've changed and there's only one guy playing that style today: Gary Moore. Moore is a rock veteran-- he's been playing professionally since he was 16 or so, and he was successful with Thin Lizzy and as a solo artist-- but in 1990, seemingly out of the blue, he released "Still Got the Blues." Immediately, the very ordinary rocker with the forgettable material was transformed into a purveyor of highpowered blues and emotion-filled solos. Most critics don't take Moore seriously, but I do, and I'm not alone; blues legends Albert King and Albert Collins both played guest spots on this CD. Collins appeared again on "After Hours" and "Blues Alive," and B.B. King on "After Hours." "After Hours" is worthwhile, but not quite as good as "Still got the Blues;" "Blues Alive" repeats too much studio material, too closely.

All of the above artists have vastly improved their material by turning to the blues, but unfortunately, not everyone has such success. Pat Travers' older material contains some tremendous blues numbers. His leisurely, threatening version of "Born Under a Bad Sign" is perhaps the definitive rendition of this muchrecorded classic, and he reinvented the blues successfully in several different songs. When he turned to the blues full-time, he should have been great. Since 1992, he's been recording for Blues Bureau International. I keep buying his cds, and I keep being disappointed. He's adopted an irritating, buzzy guitar sound, and he keeps trying to reinvent the blues in ways that consistently don't work.

It could be worse, though. You could always count on Lucky Peterson for jaunty, jazzy, slightly laid-back blues, but on his latest CD, "Lifetime," he suddenly developed a taste for go-nowhere funk. There are a few flashes of guitar brilliance and a couple of blues selections which show how good Peterson is when he plays something decent, but I'm sorry I bought the CD.

To close on a positive note, I'd like to mention a couple of artists who are "back" to the blues without ever having really left. Johnny Winter was one of the first blues stars some thirty years ago. He went through his rock period and his "authentic" period, but as of the 1988 CD "The Winter of '88," he's playing the electric blues he does best. Buddy Guy has also been playing the blues forever. He complains that the record companies wouldn't let him cut loose with feedback and distortion for most of his career. and, in fact, on his early recordings, his guitar tone has about as much personality as a code practice oscillator. On the 1988 "Damn Right, I've got the Blues," he plays the way he's always wanted to play. The follow-up, "Feels Like Rain," is about half blues and half commercialized drivel that I hesitate to classify. Fortunately, the powerful "Slippin' In" finds him back on track and back with the blues.

The author is an otolaryngologist from Waterford, Michigan.

In 1990. Gary Moore, the very ordinary rocker with the forgettable material, was transformed into a purveyor of high-powered blues.

James P. Gallagher, MD

Scrappy former boxer fights to maintain physicians' voices

By Ralph D. Ward

"Boxing seemed a peculiar sport for a medical student. I look back and wonder what was wrong with my priorities."

—James P.

It's been an adventurous life for James Gallagher, MD, from medical school in Ireland where he was a scrappy welterweight student boxer to one of the state's foremost cardiologists, and current president of the Wayne County Medical Society. Born in County Tyrone, Northern Ireland in 1932, the fifth in an ultimate full house of nine children, Doctor Gallagher attended medical school at the National University of Dublin.

Doctor Gallagher relished his college days in Dublin in the 1950s. "I look back and realize how consumed I was with sports." His favorites were football (soccer) and boxing. In the latter, Doctor Gallagher competed at the intercollegiate level, an estimable college welterweight (140-147 lbs.)

"I represented my university, boxing against Oxford and Cambridge," where he racked up "more wins than losses." Still, boxing seemed "a peculiar sport for a medical student. I look back and wonder what was wrong with my priorities."

Of more continuing interest was Doctor Gallagher's attraction to the theatre, flourishing in Dublin at that time. "There were a lot of theatres, then, and it cost very little to go, especially if you sat up in the furthest seats, what they called the "gods" sections. That highest tier was the cheapest, and that's where you'd find the medical students and

other derelicts."

After a few more years of training and residency in Ireland and England, in 1959 Doctor Gallagher was attracted to the US, where colleges and hospitals were recruiting heavily from overseas to meet a perceived physician shortage. "I had a friend interning at the old St. Mary's hospital in Detroit, and he mentioned the three major area hospitals of the time, Grace, Harper and Henry Ford. I applied for an internship at all three, and Harper was the first to respond," recalls Doctor Gallagher.

The young physician came to the US in 1959, and immediately pitched into the intern's life, which proved particularly rigorous at Harper in those years. "They had a quota of 26 interns when I arrived, but only 13 were available, so wedid double duty the whole time." After one year of a rotating internship, Doctor Gallagher gained seasoning in internal medicine and his ultimate specialty, cardiology. In 1965, he launched his own practice. In 1966, Doctor Gallagher joined Oakwood Hospital's cardiology staff, an affiliation he has continued to the present day. He has also served as an assistant professor at the Wayne State University School of Medicine.

Doctor Gallagher has been active in state and local medical societies for a number of years, including service as an MSMS delegate since the early 1980s, and on the Wayne County Medical Society's Resolutions Committee.

Doctor Gallagher, right, with Lourdes Andaya, MD, WCMS council member.

Gallagher, MD



During his term as Wayne County Medical Society president for 1996-97, Doctor Gallagher is emphasizing anti-violence initiatives, as well as working to keep physicians independent of outside forces that can hobble the future of care. As he observed in his inaugural remarks as Society president, "All of us are now familiar with how pervasively the language of business has invaded the practice of medicine, with patients becoming 'consumers,' 'clients,' or 'customers,' and physicians being only one group of a large list of 'providers."

Doctor Gallagher believes that this is a symptom of medical care standards slipping away from physicians. "As professionals we should be the ones who set the standard of care, and I see a movement underway to preserve the integrity of the profession." Based on visits back to his homeland, and to Canada, where his son is a pathologist, Doctor Gallagher sees a dark future for US medicine unless this independence is preserved. "In Britain and Canada, physicians have very little input into the standards of care, and that's an extreme loss."

Doctor Gallagher is a strong proponent of the

Multispecialty Proessional Organization (IPA) for physicians, and has extended his interest in the future of health care by taking an active part in organizing the Southwestern Michigan Physicians' Organization. "This is a slow process, but it's gathering momentum. If physicians are deciding the standards of care, they're also able to make sure the standards are upheld, and not lost to cost cutting." His experiences have convinced him that the PO is the only sure way to protect the patient-physician relationship and to ensure th continuance of the high standard of care currently maintained in the US.

The author is a Riverdale, Michigan-based freelance writer.



Doctor Gallagher, above, during his college days. At left, his family's home in Ireland.

"As
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underway to
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integrity of
the
profession."

NEWSMAKERS

Louis Saravolatz, MD, Detroit, has been appointed chief, Depart-



ment of Medicine of St. John Hospital and Medical Center. A current Clinical Professor of Medicine at the University

sity of Michigan Medical School, Doctor Saravolatz will also direct the medical residency training program for the department of Internal Medicine while overseeing 17 medical specialties. Doctor Saravolatz serves as chair of several national committees for the National Institutes of Health and for the MSMS Task Force on AIDS Education.

Daniel I. Wilhelm, MD, Port Huron, and Russell L. Dykstra, MD, Holland, received the 1996 Michigan Health & Hospital Association Physician Leadership Award for their leadership and contributions to the health field and their communities. Doctor Wilhelm has served Port Huron children and young adults through his development of an area substance abuse rehabilitation clinic, a well-baby clinic for Medicaid patients and an office designed for children with learning disabilities. Chief of staff at Holland Community Hospital, Doctor Dykstra has committed to listening before acting when solving conflicts in order to create a positive work environment. Doctor Dykstra has volunteered at the Hope College Clinic, the Ottawa County Health Department's family planning clinic, as team physician for the Holland High School football team and for the Community Health Center of Holland.

Manuel Valdivieso, MD, a principal investigator for several federally funded cancer research grants, has been selected director of the Oakwood Healthcare System Cancer Center of Excellence. Doctor Valdivieso, who is nationally known for his work in lung cancer and investigational chemotherapy, served as director of the Division of Hematology and Oncology at Wayne State University and director of the Multidisciplinary Lung Cancer Program at Wavne State University of the Detroit Medical Center. The Dearborn consultant to the National Cancer Institute has published more than 200 publications.

Michael S. Benninger, MD, chair of the Department of

Otolaryngology at Henry Ford Hospital, received the first Blue Cross Blue Shield of Michigan Foundation Excellence



in Research Award for clinical research. The Sterling Heights physician can use the \$10,000 award towards any of his projects which involve health policy or clinical research.

Paul R. Lichter, MD, chair of the University of Michigan Depart-



ment of Ophthalmology and Director of the W.K. Kellogg Eye Center, is the 100th president of the American Aca-

demy of Ophthalmology. Doctor Lichter, a specialist in treating patients with glaucoma and cataracts, intends to focus on maintaining high quality patient care throughout current healthcare restructuring. The Ann Arbor physician has been active in the 22,000 member Academy for over 20 years, having served on its Board of Trustees and as Editor-in-Chief of its peer-review journal, Ophthalmology.

Raymond Y. Demers, MD, has been named director of the Cancer Care Program at Henry Ford Health System, Arriving from Wayne State University, where he served as director of the division of epidemiology at the Karmanos Cancer Institute, Doctor Demers will oversee all aspects of cancer care including clinical, research and administrative functions. Doctor Demers also held a position as professor of family medicine, associate chair of the department of family medicine and director of the division of occupational and environmental medicine. Doctor Demer also is an appointee to the Governor's Environmental Science Board.

Deaths



Past president of the Michigan State Medical Society and Wayne County Medical Society Brock E. Brush, MD, Dearborn, died June 4. He was 85. Doctor Brush, a University of Western Ontario Medical School graduate, was appointed by Governor William Milliken to serve as chair of the Brown-McNeely Fund, an organization created to make professional liability insurance available to physicians unable to get commercial coverage.

The author of more than 100 professional journal articles was also a civic affairs activist, serving on the Board of New Detroit, the Boys Clubs of Detroit, Blue Cross Blue Shield of Michigan and the Metropolitan Fund. He was also president of the Detroit Academy of Surgery, the Detroit Surgical Association, the Detroit Academy of Medicine, the American Geriatric Society and the Michigan Cancer Foundation.

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MSMS member Ghassan Haurani, MD, Grosse Pointe Shores, died July 14 with his wife, Nina, in the crash of TWA Flight 800 off East Moriches, Long Island, New York. Doctor Haurani was a vascular surgeon at St. Joseph's Mercy Hospital since 1977. A Syrian native, he graduated from French University Medical School in Beirut, Lebanon. He was presidentelect of the Macomb County Medical Society and chair of its July 29 golf tournament. In the September issue of Michigan Medicine, Doctor Haurani was incorrectly identified as president-elect of the Oakland County Medical Society.

M. Colton Hutchins, MD, retired vice-president and chief of medical staff at William Beaumont Hospital, died August 29. He was 73. The Tufts University Medical School graduate enlisted in the U.S. Army Medical Corps where he attained the rank of captain and served as chief of medicine at Clark Field in the Philippines. Doctor Hutchins operated an office in Detroit for 22 years before becoming attending physician at William Beaumont Hospital in 1977, then chief of medicine from 1979 to 1990. During his career, the internal medicine specialist taught interns and residents at Harper and Grace Hospitals and served as clinical assistant professor at Wayne State University School of Medicine. He was a member of the MSMS, the American Society of Internal Medicine, the American College of Physicians and the American College of Utilization Review Physicians.

William G. Birch, MD, a former Kalamazoo ob/gyn who wrote a bestselling book and founded the Western Michigan University Physician Assistant department, died September 8. He was 87. Doctor Birch, who delivered about 14,000 babies by his retirement in 1974, sold more than 10 million copies of his book, A Doctor Discusses Pregnancy. He also founded, then served as clinical director for, the country's first physician's assistant program to offer a bachelor's degree at Western Michigan University. A Northwestern University Medical School graduate, Doctor Birch served 29 of his 40 years of practice in Kalamazoo, including a position as chief of obstetrics at Bronson Methodist Hospital. He was past president of the Kalamazoo Academy of Medicine, a member of MSMS, the American College of Surgeons and the American College of Obstetricians and Gynecologists.

Longtime supporter of the Detroit Institute of Arts and dermatologist Coleman Mopper, MD, died September 16. He was 78. An art history buff who was pursuing a master's degree in art history from Wayne State University, Doctor Mopper actively volunteered for the Detroit Institute of Arts. In October, he was to have received the organization's

first lifetime achievement award for distinguished service to the museum. Doctor Mopper, a University of Georgia Medical School graduate, opened a private practice in Detroit in 1949 and continued to serve in the Detroit area for more than 40 years. He was a clinical professor of dermatology at Wayne State University and a founding member of Sinai Hospital. Doctor Mopper was a member of the AMA, MSMS, Wayne County Medical Society, the American Academy of Dermatology and a past president of the Detroit Dermatological Society.

Former Detroit health commissioner, Charles P. Anderson, MD. died September 7. He was 86. Before working for the state health department, Doctor Anderson opened a private practice in 1935 in North Carolina and later worked as deputy director of Wayne County Health Department. He took a position as medical director for Michigan's health department in 1951 before becoming the health commissioner. Doctor Anderson, a Northwestern University Medical School graduate, was a member of the AMA and MSMS.

New Members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Maura L. Bagos, DO, Birmingham

Donna J. Boyd, MD, Marquette

Megha S. Chavan, MD, Farmington

Andrea J. Eisenberg, MD, Farmington

Nikhil K. Hemady, MD, Pontiac

Nadine R. Jennings, MD, Pontiac

Farhan M. Khan, MD, Flint

Rula Mahayni, MD, Bloomfield Hills

Kim Mahler, DO, Negaunee

Diane Paratore, DO, Bloomfield Hills

Ida R. Ricci, MD, Shelby Twp.

Elzbieta A. Rozmiej, MD, Armada

Matthew Supron, DO, Marquette

Timothy Watkins, MD, Birmingham

The physicians of the University of Chicago Medical Center invite you to put us on your medical team.

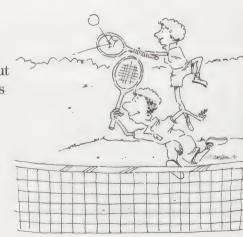
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PEOPLE

Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Jonathan D. Tunis, MD, 2102 Wyndham Hill Dr., Apt. 103, Grand Rapids, MI, 49505

Action, Date Taken: Probation - 3 years, 8-21-96.

Reason: Criminal Conviction - Drug Related

Name: Elena V. Perry-Thornton, MD, 4032 G Runny

Meade Ln, East Point, Atlanta, GA, 30344

Action, Date Taken: Limited License, Fine - \$250, 9-20-96

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Robert K. Hafford, MD, 700 Borton Ave, Essexville, MI 48732

Action, Date Taken: Probation - 1 year, Reprimand, Fine - \$1,000, 9-20-96

Reason: Negligence/Incompetence

Name: Hilda A. Habenicht, MD, 9146 4th St., Berrien Springs, MI 49103

Action, Date Taken: Permanent Surrender of License,

Summary Suspension Dissolved, 9-20-96

Reason: Drug Related

Name: Sajida A. Ahmed, MD, 1430 Arlene, Clare, MI 48617

Action, Date Taken: License Suspended - 2 yr., 8-21-96 Reason: Negligence/Incompetence

Name: Samuel Sefton, MD, 252 E. Lovell, Kalamazoo, MI 49007

Action, Date Taken: License Suspended - 1 yr. effective 11-20-95, Summary Suspension Dissolved, Fine - \$10,000, 7-31-96

Reason: Criminal Sexual Conduct

Name: Henry J. Winkler, MD, 29240 Grandview, Harrison Twsp., MI 48045

Action, Date Taken: Reinstatement Denied, 7-30-96

Name: Steven K. Campbell, MD, 105 E Chicago St., Coldwater, MI 49036

Action, Date Taken: Reinstatement Denied, 8-5-96

Name: Stephen O. Anders, DO, 4101 Airport Fwy. #101, Bedford, TX, 76021

Action, Date Taken: License Suspended - 6 mo. & 1 day, 8-1-96

Reason: Sister State Disciplinary Action

Name: John C. Dickson, Jr., DO, 3272 West Rd., Trenton, MI 48183

Action, Date Taken: Fine - \$100, 8-1-96

Reason: Negligence

Name: Paul R. West, DO, 113 Edgewood St., Wheeling, WV, 26003

Action, Date Taken: Probation, Fine \$500

Reason: Failure to Report/Comply Sister State Disciplinary Action, 8-31-96

Name: Joe W. Morgan, DO, 3125 S. Mendenhall Rd #408, Memphis, TN 38115

Action, Date Taken: Probation, Fine \$500, 8-31-96 Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Gordon L. Grenn, DO, 4002 Raulerson Rd., Lake Worth, FL, 33463

Action, Date Taken: Reprimand, Fine \$250, 8-1-96 Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Max M. Allen, DO, 599 E. Main St., Benton Harbor, MI 49022

Action, Date Taken: License Suspended - 6 mo., Probation - 6 mo., Fine - \$500, Limited License - commencing at end of suspension period, 10-1-96

Reason: Negligence/Incompetence

Name: Surindar S. Bedi, MD, 2207 Belchery Court, Clearwater, FL 34624

Action, Date Taken: Reinstatement Denied, 7-26-96

Name: Stephen Schweinsberg, MD, 25307 Dequindre Rd., Madison Heights, MI 48071

Action, Date Taken: Relicensure Denied, 7-26-96 Reason: Failure to Meet Licensing Requirements

Name: Joseph Natole, Jr., MD, 4701 Towne Centre, Suite 103, Saginaw, MI 48604

Action, Date Taken: License Suspended - 3 mo., Upon reinstatement, License Limited - min. 3 mo., Upon reclassification to unlimited license, probation - min. 2 yrs., Fine \$50,000, 8-29-96

Reason: Negligence-Incompetence

Name: Joseph Natole, Jr., MD, 4701 Towne Centre, Suite 103, Saginaw, MI 48604

Action, Date Taken: By Order of the Saginaw County Circuit Court, the Final Order of the Board of Medicine date 7-30-96 & effective 8-29-96 is Stayed, 8-15-96



Most Physicians Overestimate Their Immunization Rates

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 - Speakers Bureau
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 - Awareness Programs
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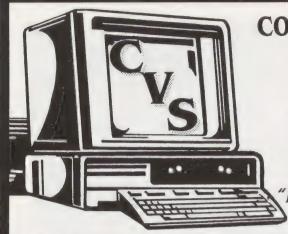
These methods include improving knowledge about immunization policy and procedures, checking immunization status at every visit and auditing their own immunization rates.

A speakers bureau is available to any group that wants to improve immunizations rates of their patients.

We encourage individual practices, hospital department meetings and county medical societies to further educate themselves on vaccines.

Please Call Kathy Holcomb, Coordinator at 517-336-5707 or e-mail to kholcomb@msms.org or Jean Capriotti at 517-336-5706 or e-mail to jcapriotti@msms.org.

Peer Education Project on Immunization Immunization Education for Health Providers



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International College of Surgeons - Michigan Division

ANNUAL SCIENTIFIC SESSION

February 19, 1997 • 8:00 a.m. - 3:30 p.m. • Sinai Hospital • Zuckerman Auditorium • 6767 West Outer Drive • Detroit, Michigan

PROGRAM DIRECTORS

Eduardo Phillips, M.D., F.A.C.S., F.I.C.S., President, International College of Surgeons, Michigan Division, Chairman, Department of Surgery, Sinai Hospital, Detroit, MI, Clinical Assistant Professor of Surgery, Wayne State, Detroit MI

Andrew Saxe, M.D., F.A.C.S., F.I.C.S., Secretary /Treasurer, International College of Surgeons, Michigan Division, Section Chief, Endocrine Surgery, Program Director, Department of Surgery, Sinai Hospital, Detroit, MI, Clinical Assistant Professor of Surgery, University of Michigan, Ann Arbor, MI

GUEST SPEAKERS

Ian Jackson, M.D., D.CS (hon.), F.R.C.S., F.R.A.C.S., Chief, Division of Plastic Surgery; Providence Hospital, Southfield, MI LECTURE: Craniofacial Reconstruction

Timothy C. Fabian, M.D., F.A.C.S., Professor and Deputy Chairman of Surgery, Director of Trauma, University of Tennessee at Memphis, Memphis, TN LECTURE: Difficult Abdominal Wound Closure

Constantine P. Karakousis, M.D., Ph.D., Chief, Soft Tissue-Melanoma, Professor of Surgery, State University of New York at Buffalo, Director, Surgical Oncology, Millard Fillmore Hospital, Buffalo, NY

LECTURE: Current Management of Malignant Melanoma

David Wisner, M.D., Professor of Surgery and Cheif of Trauma, University of California, Davis Medical Center, Sacramento, CA LECTURE: New Approaches to the Initial Management of the Trauma Patient

Nathan Kaufman, M.D., Chairman, Radiation Oncology, Sinai Hospital, Detroit, MI and Michael Lutz, M.D., Section Chief, Urology, Department of Surgery, Sinai Hospital, Detroit, MI

LECTURE: Advances in the Diagnosis and Management of Prostate Cancer

Susan Wang, M.D., M.P.H., Medical Epidemiologist, Centers for Disease Control and Prevention, Atlanta, GA LECTURE: Transmission of AIDS in the Health Care Setting

OBJECTIVES: This program is designed to update knowledge in current issues in Surgery. It is open to physicians, residents and other interested health care professionals.

CREDIT HOURS: The International College of Surgeons - United States Section is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The International College of Surgeons - United States Section designates this continuing medical education activity for 6 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

REGISTRATION FEE: \$100 for physicians; \$50 for other health care professionals. There is no charge for residents or fellows of ICS to attend. Complimentary valet parking is available at the Zuckerman Auditorium Entrance off of West Outer Drive.

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ACROSS THE STATE



Macomb, Oakland, Upper Peninsula medical societies featured this month



The Macomb County Medical Society held a golf tournament and dinner July 29 in memory of Nina and Ghassan Haurani, MD. The event featured golfing and dinner, followed by a tribute to the Hauranis who died in the July 14 crash of TWA flight 800. The more than \$11,000 raised at the golf outing, for which Doctor Haurani had served as chair, will benefit the Macomb County Medical Society Foundation-Haurani Scholarship Fund. Among those attending the benefit were the Hauranis' children, from left to right: Chad, Joe, Randa and Zeina.

The second annual "Docs and Jocks Run" held Aug. 17 raised \$20,000. The four mile event, sponsored by the Oakland County Medical Society, Metro Rehab and the Detroit Lions, raises awareness of domestic violence. The funds raised this year will be given to domestic advocacy organizations, such as shelters and educational programs, in Southeastern Michigan. Oakland County Medical Society president, Stanley A. Dorfman, MD, here announcing the purpose of the race, believes that it "promotes healthy living while raising awareness of domestic violence."





MSMS directors and their spouses from northern reaches of the state joined colleagues as the Upper Peninsula Medical Society held its annual meeting September 21 and 22 at Escanaba. The meeting serves as the area physicians annual opportunity to discuss business and medical issues. Pictured from left to right: Barbara Gilbert, Calumet; Pat Musson, Traverse City; Janet Gregory, Traverse City, President - MSMSA. Back row from left to right: Carl F. Hammerstrom, MD, AMA-alternate delegate, and Lynne Hammerstrom, Marquette; Dave Gilbert, MD, District 13 director, Calumet; Ken Musson, MD, MSMS Board vice chair, Traverse City; Beverly Bisset and Ron Bissett, MD, Gladstone, UP Medical Society President; Jaak Pahn, MD, District 12 director, and Sandy Pahn, Sault Ste. Marie.

What is happening in your neck of the woods?

Michigan Medicine would like to develop and expand this monthly feature to include news from various sources across the state. That includes county medical societies, specialty medical societies, physician organizations, business coalitions and other organized groups involving physicians. Send your news by mail, fax, e-mail or phone to Tom Seely, chief of physician outreach programs, P.O. Box 950, East Lansing, MI 48826-0950; fax (517) 337-3490; e-mail tseely@msms. org; or phone (517) 336-5770. Photos in either black and white or color are accepted and will be run on a space available basis.

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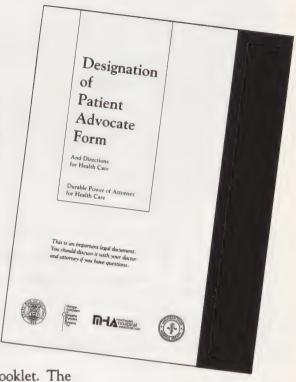
Durable Power of Attorney for Health Care Order Form

MSMS urges individual physician offices to order the new Durable Power of Attorney for Health Care Designation Forms to distribute to patients as a public relations activity. The forms were developed and approved by MSMS, the State Bar of Michigan, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons.

The forms provide patients with the means to appoint a patient advocate to make health care decisions for them if they become incapacitated. Distribution of the document serves as a goodwill gesture that can demonstrate to patients how physicians are working to help them.

Designation Forms and accompanying brochures can be ordered through MSMS. Price is 40 cents for the pair when ordering 100 or more. Under 100, the price is 45 cents. Minimum order is 50.

The Designation Form is an eight page 8 1/2 by 11 booklet. The document is designed to be a "user friendly" form, particularly for older patients. The short patient brochure accompanying each form covers more detailed information about the new durable power of attorney law.



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Doctors' "front-line" staffers

Medical assistants aid in administrative and clinical duties

By William Kendy

It's to physicians' benefit to encourage their employees to be part of the association.

In this rapidly changing medical world, it's imperative that physicians and their staff are versed in the latest technology and medical breakthroughs. Because medical assistants are doctors' "front line" in terms of dealing with patients and insuring that a medical practice runs smoothly and efficiently, their up-to-date knowledge of the profession is essential. The Michigan Association of Medical Assistants allows for medical assistants to stay informed.

The MSMA currently has over 1,100 members in 18 chapters throughout the state. It is a society devoted to providing educational services for the self-improvement of its members and to promote the professional identity and status of its members and the medical assisting profession, through education and credentialing.

A medical assistant should be "cross-trained"

in a variety of areas so they are "able to perform a number of duties," according to Carol Dew, past president of the MSMA. "It's very difficult to work in a physician's office and not be able to understand both the administrative and clinical sides."

MSMA encourages medical assistants to participate in the national certification program to illustrate the general medical knowledge. In order to take the certification exam, an MA must have worked full time for 12 months or part time for 24 months. After January of 1998, MAs also must have graduated from an accredited school. Once medical assistants are

certified, they need to revalidate their certification every five years.

"The education requirements will add greater credence to our credentials," said Karen Graham,

current MSMA president. "We'll be able to guarantee that all MAs have a certain standard of education and are competent in practical skills."

Through its affiliation with the American Association of Medical Assistants, it offers insurance programs, legal counsel and a number of other benefits. Both Graham and Dew feel that doctors should

encourage their medical assistants to join MSMA.

"It's to physicians' benefit to encourage their employees to be part of the association," said Ms. Dew. "Unfortunately, a lot of physicians have never heard of MSMA...they just haven't been exposed to it."

One doctor who is an avid supporter of MSMA is Joseph Weiss, MD, a Livonia rheumatologist and member of the MSMS Board of Directors. In a recent column from The Record, the official BCBSM publication, Doctor Weiss remarked "a doctor may see a patient for 15 minutes, but the patient may spend much longer in the office with the MA, asking about the billing, treatment or prescriptions, so the MA gets to know the patient."

While the knowledge acquired through AAMA certification and education offers invaluable skills when dealing with patients, Ms. Graham believes the organization's worth stretches beyond this, offering members the opportunity of "life-long friendships with people from all over the state."

For information on MSMA membership, contact Karen L. Graham, 7250 Capri Drive, White Lake, MI 48383, Fax 810-681-1670. ■

The author is a Holt, Michigan-based freelance writer.



Karen L. Graham

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MSMS Meetings

November

20. Board of Directors Meeting. Location: MSMS Headquarters, East Lansing. Contact: Irene Frost at MSMS at (517) 336-5734.

20, MSMS Capitation Seminars. Location: Amway Grand Plaza Hotel, Grand Rapids. Contact: Darla Brandon at MSMS at (517) 336-5769.

21, Health Professions Education-Past Present and Future. Location: Radisson Hotel, Lansing. Co-sponsored by MSMS. Contact: Sherry L. Fent at MSMS at (517) 336-5730.

January

15, MSMS Board of Directors Meeting. Location: MSMS Headquarters, East Lansing. Contact: Irene Frost at MSMS at (517) 336-5734.

AMA Meetings

December

8-11, 1996 AMA Interim Meeting. Location: Atlanta Marriott Marquis, Atlanta, GA. Contact: Judy Marr at MSMS at (517) 336-5744.

January

8-11, 1997 AMA State Legislation Meeting. Location: Palm Desert, CA. Contact: Greg Aronin at MSMS at (517) 336-5739.

March

16-19, AMA 1997 Leadership Conference. Location: Marriott Hotel, Philadelphia, PA. Contact: Kevin A. Kelly at MSMS at (517) 336-5743.

June

22-26, AMA Annual Meeting. Location: Hyatt Regency, Chicago, IL. Contact: Judy Marr at MSMS at (517) 336-5744.

Michigan Specialty **Society Meetings**

November

19, OSHA and the Medical Industry: A Compliance Update. Location: Radisson Hotel, Lansing. Contact: KEYE PRODUCTIVITY CENTER, PO Box 410, Saranac Lake, NY 12983-0410.

21. Graduate Health Professions Conference. Location: Radisson Hotel, Lansing. Contact: Sherry L. Fent at MSMS at (517) 336-5730. Co-sponsored by MSMS.

December

4, Michigan Dermatological Society Regional Scientific Meeting. Location: Wayne State University, Detroit. Contact: Jennifer Anibal at MSMS at (517) 336-7595.

7, Michigan Society of Pathologists Meeting. Location: Dearborn Inn, Dearborn. Contact: Melissa K. Wiegand at MSMS at (517) 336-7586.

January 1997

31-Feb. 2, Michigan Society of Medical Assistants Midwinter Seminar, Location: McCamly Plaza Hotel, Battle Creek. Contact: Sue Storey, CMA-C, 2336 Ramblewood Dr., Kalamazoo, MI 49009.

February 1997

14-16, AAMA Board of Trustees Meeting. Location: Chicago. Contact: Caroline Kimmel at MSMS at (517) 336-7587.

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EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

November

19 & 26, Bar-Levay Educational Association Ongoing Seminar Series "The self-image of the psychotherapist: Its effect on the treatment." Location: Southfield. Contact: Lester Potempa, DO, Bar-Levay Educational Association, 3000 Town Center Suite 1275. Southfield, MI 48075; Phone 810-353-5333. Approved for: 4 Category 1 credits. No registration fee.

December

3&10, Bar-Levay Educational Association Ongoing Seminar Series "The recurring dilemma: How to double check the reality perceptions of the psychotherapist." Location: Southfield. Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center Suite 1275, Southfield, MI 48075; Phone 810353-5333. Approved for: 4 Category 1 credits. No registration fee.

7, 13th Annual Clinical Update in Pulmonary Medicine. Location: Trump World's Fair Casino. Contact: Center for Bio-Medical Communication, In., 80 W Madison Ave, Dumont, NJ 07628; Phone 201-385-8080, Fax 201-385-5650. Approved for: 7 Category 1 credits. Registration fee: \$175 before Oct. 7; \$225 after Oct. 7. Sponsored by: Deborah Heart & Lung Center.

17&24, Bar-Levav Education Association Ongoing Seminar Series "Extratherapeutic contacts in group psychotherapy: Risks and benefits." Location: Southfield. Contact: Lester Potempa, DO, Bar-Levay Educational Association, 3000 Town Center Suite 1275, Southfield, MI, 48075; Phone 810-353-5333. No registration fee.

January

27-31, Echo Hawaii. Location: The Westin Maui, Maui, Hawaii. Contact: American College of Cardiology, PO Box 79231, Baltimore, MD, 21279-0231, Phone 1-800-253-4636. Approved for: 26 Category 1 credits. Registration fee: ACC members - \$570 by Jan. 10; Non-members - \$675 by Jan. 10. Registration after Jan. 10 will be onsite only and \$50 more.

February

3-5, Cardiovascular Conference at Snowshoe, Location: Mountain Lodge Conference Center, Snowshoe, West Virginia. Contact: American College of Cardiology, Attn: EP, PO Box 79231, Baltimore, MD 21279-0231; Phone 1-800-253-4636, ext. 695, Fax 301-897-9745. Approved for: 14 Category 1 credits. Registration fee: ACC Members: \$400 by Jan. 20; Non-Members: \$475. Registration is onsite only after Jan. 20 and fees are \$50 higher.

7-9, Clinical Endocrinology for Primary Care Physicians. Location: MGM Grand Hotel, Las Vegas, NV. Contact: Medical Education Resources, 1500 W Canal Court, Suite 500, Littleton, CO 80120-4569; Phone 1-800-421-3756, Fax 303-798-5731. Approved for: 11 Category 1 credits. Registration fee: \$375.

12-15, Cardiovascular Conference at Snowbird. Location: Cliff Lodge, Snowbird, UT. Contact: EP, PO Box 79231, Baltimore, MD, 21279-0231, Phone 1-800-253-4636, ext. 695. Approved for: 19 Category 1 credits. Registration fee: ACC members - \$525 by Jan. 29: Non-members - \$620. Registration is on-site only after Ian. 29 and fees are \$50 higher.

15-16, Infertility Evaluation and Treatment: A Comprehensive Review for the Primary Care Physician. Location: Sheraton Palace Hotel, San Francisco, CA. Contact: Center for Bio-Medical Communication, Inc., 80 W Madison Ave, Dumont, NJ 07628; Phone 201-385-8080, Fax 201-385-5650. Approved for: 10.5 Category 1 credits. Registration fee: \$495 before Dec. 15; \$550 after Dec. 15.

15-19, Selected Topics in Internal Medicine. Location: Rancho Bernardo Inn & Resort, San Diego, CA. Contact: Registrars, Mayo Foundation, Section of Continuing Medical Education; 200 First St. S.W., Rochester, MN 55905; Phone 1-800-323-2688, Fax 507-284-0532. Approved for: 25 Category 1 credits. Registration fee: \$625.

21-23, Advances in Diagnostic and Therapeutic Cardiac Catheterization. Location: Walt

EDUCATIONAL OPPORTUNITIES

Disney World Swan, Lake Buena Vista, FL. Contact: Am. College of Cardiology, Attn: EP, PO Box 79231, Baltimore, MD, 21279-0231, Phone 1-800-253-4636. Approved for: 17.5 Category 1 credits. Registration fee: ACC members-\$450 by Feb. 7; Non-members \$525 by Feb. 7. Registration is onsite only after Feb. 7 and \$50 more.

24-28, Echocardiographic Workshop on 2-D and Doppler Echocardiography at Vail. Location: Marriott's Vail Mountain Resort, Vail, CO. Contact: American College of Cardiology, PO Box 79231, Baltimore, MD, 21279-0231, Phone 1-800-253-4636. Approved for: 20.5 Category 1 credits. Registration fee: ACC members - \$530 by Feb. 10; Non-members - \$625 by Feb. 10. Registration after Feb. 10 will be on-site only and \$50 more.

March

7-9, Management of the HIV-Infected Patient: A Practical Approach for the Primary Care Practitioner. Location: Crowne Plaza. Manhattan, New York City, NY. Contact: The Center for Bio-Medical Communication, Inc., 80 W Madison Ave, Dumont, NJ, 07628, Phone 201-385-8080, e-mail cbcbiomed@aol.com. Approved for: 20.25 Category 1 credits. Registration fee: \$495 by Jan. 24 for physicians and \$295 for physiciansin-Training and allied health professionals.

April

12-18, The International Society for Magnetic Resonance in Medicine Fifth Scientific Meeting and Exhibition. Location: Vancouver Trade and Convention Centre. Contact: Charles S. Springer, PhD,

Chair, International Society for Magnetic Resonance in Medicine. Student Stipend Committee, 2118 Milvia Street, Suite 201, Berkeley, CA, 94704, USA. Approved for: up to 50 Category 1 credits. Registration fee: \$295.

May

9-16, American Occupational Health Conference. Location: Orange County Convention Center, Orlando, FL. Seven two-day courses will be offered in conjunction with the conference. Contact: ACOEM, 55 W. Seegers Rd., Arlington Heights, IL 60005; Phone 847-228-6850, ext. 152. Approved for: 13 Category 1 credits (for conference). Credits vary for courses. Registration fee for conference: ACOEM members - \$180; Nonmembers - \$300. One-day registration fee: ACOEM members - \$110; Non-members - \$210.



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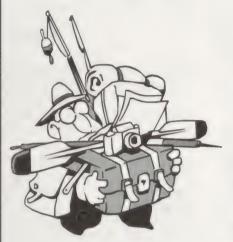
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Michigan Medical Advantage

Ideal opportunity for physicians to stay in the driver's seat

By W. Peter McCabe, MD



he latest buzz letters in the alphabet soup of managed care are "MSO"... standing for "management service organization." MSOs seem to be anything you want them to be; but the common thread to all of them, no matter how each evolves, is that they address everything in the group practice of medicine other than the financial risk and actual medical decision-making.

To be sure, we've had such support organizations in the past — billing services, marketing advisers, computer consultants, personnel contractors and the like. But these benefits were offered in the fee-forservice context which, in essence, amounted to a cost-plus approach to health care delivery.

Physicians must assume risk

What has changed the equation is that physicians and other providers are being asked—really forced—to assume part of the risk, at least to the extent of projecting cost of services, and sticking to that price.

In a certain way, this is not all that revolutionary. Think about General Motors making a car. Some days, when there is a high absentee rate and the assembly line slows, it will end up costing GM more than usual to make a single car. Other days, when things are humming, it will make a significant profit. It's the task of the manufacturer to take all those variables into account so that

its product is priced to make a profit and yet be competitive.

I'm a plastic surgeon, and actually, we in that field have, for years, had a taste of this type of pricing in cosmetic surgery. Since such services are not reimbursed by insurance, patient expenditures are out in the open and enjoy a certain honesty that all the up-and downcoding and hidden stratagems of third party reimbursement do not. Call my office and we'll quote you a price... and we'll stick to it whether the operation takes me two hours or four hours.

Board moves ahead with Michigan Medical Advantage

Although relatively simple on a micro scale, this type of cost analysis becomes somewhat burdensome for the small to medium practice when it gets to the big arena of cost efficient health care delivery. Here the keys to success are analogous to success in real estate, where the three key factors are location, location, location. In cost-efficient, risk-bearing health delivery it's data, data and more data.

Few physician groups have the wherewithal to apply such analysis to their practices, forcing them to joint venture with support entities with which they may not be entirely comfortable. It's to address this comfort level—or lack thereof—that MSMS is going forward to start its own MSO. No matter what

skepticism there may be toward other potential venture partners, there can be no doubt that MSMS, a creature of physicians exclusively for physicians, will serve doctors' interests without compromise.

MMA deserves your support

MSMS soon should be announcing details of its MSO, Michigan Medical Advantage, in terms of investment opportunities for the profession. This presents an ideal opportunity for physicians to stay in the driver's seat and to retain a measure of control over their own destiny. It certainly deserves all your support.

Watch these pages, Medigram, your county bulletins and the MSMSNET home page for details on how you can improve your status and strengthen your position by joining your colleagues in this Michigan physician-run corporation. Take the Advantage!

Doctor McCabe is MSMS president.

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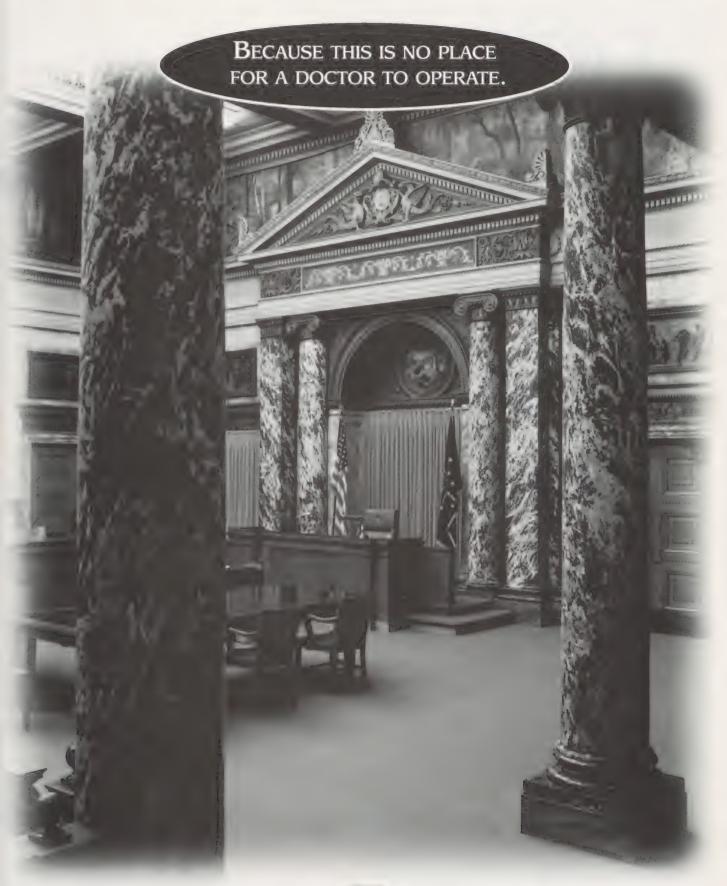
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COVER STORY



Medicaid Capitation Physicians Have Time to Review Options 20

When the state's Medicaid administration announced earlier this year it would move to a fully capitated system, some Michigan physicians and their patients were pressured prematurely to affiliate with one health care plan or another. To help alleviate their anxiety, MSMS and state government worked together to provide accurate updates, particularly in southeast Michigan, where capitation will first become effective. Now that the request for proposals has been released, Michigan Medical Advantage, a management services organization formed by MSMS, is offering its many support services to physicians. In this issue Michigan Medicine examines the facts and fiction surrounding Medicaid's move to managed care—and gives physicians the tools for taking control. By Karen Bouffard

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On the cover: Michigan Medicaid Physician Daniel J. Wilhelm, MD, a Port Huron Pediatrician, reviews a patient's chart.

Restructuring Michigan Health Care - the State's Plan 2

Michigan Department of Community Health officials explain how they will involve health care providers, consumers and advocates during the Medicaid transition. You will also find here an outline of the state's plan for informing physicians and patients about the changes.

By Robert Smedes

MSMS Response - Use Your Medical Society

While physicians take steps to prepare for Medicaid capitation, MSMS advocates with Community Health officials regarding physicians' concerns. This article describes the issues MSMS has explored and plays out the help and guidance MSMS can offer physicians through the transition. The message: Take your time, exercise caution and diligence, and "use MSMS" to guide the way.

By Mary Anne Ford



December 1996 Volume 95, Number 12

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LETTERS



Doctors should unite with MSMS to tackle changes

This letter is sent to commend MSMS on the initial steps to provide MSO services for physicians in the state of Michigan. Certainly it is a bold step but one which is deemed necessary under the current atmosphere of change in health care today. Physicians are currently overwhelmed by the numerous and large business interests that are threatening to control medicine as a whole. It is time that physicians become more involved in determining the direction of health care for their patients.

I recall several years ago that MSMS made another bold move in providing malpractice insurance for its physicians as you pointed out during our meeting on October 1, 1996. Indeed, individual physicians and small physician organizations are not of sufficient size and have limited resources to take on HMOs and other large business entities; therefore, it is important for physicians to join under the umbrella of their State Medical Society to form a bond to protect the interests of physicians and their patients in this rapidly changing health care environment. Granted, these are bold moves, but certainly necessary; physicians can choose to allow big business to decide the direction of health care in today's market, or they can join with their State Medical Society and control their own destiny.

Donald R. Samuel, MD
Tecumseh

Physicians do have legal access to their records

I am a board-certified dermatologist in Lansing, MI. who feels the people managing the Bureau of Occupational and Professional Regulations and working with the Board of Medicine are out of control.

I recently was acquitted of a manslaughter charge that reached national attention. The Bureau of Occupational and Professional Regulations had inappropriately initiated an investigation and compiled a file on my medical license at the time of my arraignment, without the knowledge and consent of the Board of Medicine. As you may know, I was tried and acquitted by my peers approximately one year after the arraignment. Shortly after the trial, the investigation and file were closed.

Under the Freedom of Information Act, I requested a copy of my file on my medical license. My request was denied by the Bureau of Occupational and Professional Regulations. Even though this is a

violation of the Freedom of Information Act and a direct violation of the Public Health Department Statute that allows physicians to review their historical records, they continued to deny me access to my file.

I have taken further steps to hopefully obtain this file. Michigan State Medical Society License and Disciplinary Sub-committee has agreed to listen to my concerns regarding the practices of the Bureau of Occupational and Professional Regulations and the lack of due process for physicians. I find it astonishing and absolutely absurd that the Government feels it is justified in having secret files.

Through this letter, I hope to inform my colleagues of the easy access to information compiled on one's medical license, both at the state and national level; the state information is easily obtained by writing to Lauren G. VanSteel, Bureau of Occupational and Professional Regulations, PO Box 30018, Lansing, MI 48909 and requesting under the Freedom of Information Act a copy of one's medical license. The national information can be obtained from The National Practitioners' Data Bank at 800-767-6732.

Gregory G. Messenger, MD Lansing

Express your point of view in Michigan Medicine.

To submit a letter, mail, fax, or e-mail it to Michigan Medicine, 120 W. Saginaw St., East Lansing, MI 48823; fax (517) 337-2490; or e-mail jmarr@msms.org. Please type letters you submit for publication. Letters are published at the discretion of the editor and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Michigan State Medical Society.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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Question:

If you had \$1 million to give to any group or cause, to whom would you give it and why?

I know this sounds self-serving, but my first responsibility would be to my family. I have 10 grandchildren with two more hopefully on the way, my

youngest son was married over Labor Day, and I would give the money to them.

Gerald H. Mandell, MD

Detroit, Clinical Pathology

I would choose to give to Doctors Without Borders (Medeins San Frontieres) because of my great admiration for these selfless men and women who have answered medicine's highest calling, in serving the truly needy in many corners of the world. They serve in many instances in perilous circumstances, placing the needs of those they serve over their personal safety. While we enjoy the practice of medicine in our clean, safe, well-equipped offices and hospitals, making a comfortable living, it behooves us to be mindful of our medical brethren in the trenches!

Liz Hutchinson, MD

Lansing, Dermatology

I would give the money to the Salvation Army because I think they would make the best use of it. The top causes of death are caused or influenced by choices. The Salvation Army not only provides for the necessities of food, clothing and shelter, but also provides an avenue for changing lives and liberating those who need to be liberated from past mistakes.

Fred M. Busse, MD

Niles, Pathology

I would distribute it among organizations where, in my experience, it would make a difference: 10 percent to each—my church, medical school, hospi-

tal and arthritis foundation; 20 percent to each—WCMS Foundation, MSMS Health Education Foundation and Detroit PBS Channel 56 (All are tax exempt, so NONE to the IRS).

Gilbert B. Bluhm, MD

Detroit, Rheumatology

I would give to the local United Way because it helps the poor in our communities.

Saundra Blanchard, MD

Cadillac, General Practice

It would be a privilege to be able to donate \$1 million. There are so many worthwhile candidate charities that, to a large extent, the recipient is decided for emotional reasons. The largest impact would probably be made in two dissimilar areas; medical care for the poor (such as Clinica Santa Maria in Grand Rapids) and the arts (such as the Grand Rapids Symphony). Both types of organizations are very fragile and always nearly broke; if they were to fail in a community, it would take years to get them back.

Paul O. Farr, MD

Grand Rapids, Gastroenterology

BackTalk is a nonscientific sampling of Michigan physicians' opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to Michigan Medicine, BackTalk, P O Box 950, East Lansing, MI 48826-0950, or fax to (517) 337-2490, or e-mail jmarr@msms.org.

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Patient Record Legality Issues

by Richard D. Weber, Legal Counsel

O: Can a physician who is the recipient of a patient's medical records legally provide them to the patient, insurer and/or attornev without verbal or written permission from the originating physician?

A: The physician-patient privilege belongs to the patient, not the physician. Legally, the physician who is the recipient of the patient's medical records may legally provide the information to any other person so long as the patient has specifically waived the privilege by written authorization for disclosure of the records. As a matter of courtesy, however, it may be appropriate under the circumstances for the physician to notify the originating physician that the records will be transferred. Absent a specific written direction by the patient, the physician who is the recipient of the records has no legal duty to furnish the records to an insurer, attorney, or any other person. Upon the request of a competent adult patient, records must be furnished to the patient, except with respect to mental health records in the instance where the physician determines that the release of such records would be detrimental to the recipient of others. In all instances, except when the

records are furnished to another physician for further diagnosis or treatment and originals are necessary, such as x-rays, the physician should retain the original records. Copies should be furnished and the physician may charge a reasonable copying fee.

Q: Is a physician required to produce a patient's records upon receipt of a subpoena in a case where the physician is not a party?

A: Patient records generated out of the professional relationship between the physician and patient are confidential and protected by the physician-patient privilege. Such records should not be disclosed to anyone other than a competent adult patient, subject to the mental health records exception, without one of the following: (1) a written authorization and consent signed by the patient or the patient's guardian, specifying to whom the records are to be delivered and identifying the records; or (2) a certified copy of a court order requiring production of the records, specifying to whom the records are to be delivered and identifying the records. Without either a written authorization or certified court order, a subpoena should

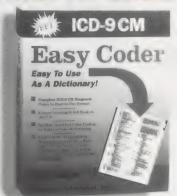
not be honored, but it should also not be ignored. The attorney issuing the subpoena should be contacted and requested to furnish the authorization or court order. The request should be confirmed by letter to the attorney with a copy to the patient or patient's attorney. If the attorney refuses to comply with the request, the physician should contact his or her attorney.

Mr. Weber is the senior partner of Kerr, Russell & Weber, PLC.

Editor's note: If you have legal questions you would like answered by MSMS legal counsel in this column, send them to Judy Marr, Editor of Publications, P.O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490 or E-mail them to imarr@msms.org.

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MSMS Members Now Can E-mail Outstate Caucus Leaders

By Carl F. Hammerstrom, Jr., MD, FCCP

Outstate Caucus members and those interested in the activities of the caucus can now view online information at http://www.msms.org/osc. The Outstate Caucus consists of seated delegates from all county societies except Wayne County and meets once a year at the House of Delegates. The Caucus nominates outstate candidates for MSMS offices to be vote upon at the House of Delegates. The Outstate Caucus, which is governed by its own rules and regulations, can also address issues of significance and special interest to outstate members.

The past few years, the Outstate Caucus has discussed re-working its nomination and voting procedures. Time contraints at the House of Delegates annual meeting have led to frustration of this goal.

As your new chair for the Oustate Caucus, I asked MSMS leadership to support a web page for the Caucus to provide current information and allow our members to prepare for the annual meeting without unnecessarily travelling to meetings. Bill DeCourcy, Claudia Skutar, Donna Brown and David Fox have helped me in the design.

The web site featuring the Caucus contains its rules and regulations and other information pertinent to the activities of the caucus. The new page contains contact information for the Executive Committee of the Outstate

Caucus, including an e-mail directory. This directory can be used to contact any member of the Executive Committee instantly, and will be a tremendous tool for coordinating communication and caucus activities.

Please log on. If you have comments, please contact a member of the executive committee. Donna Brown or David Fox also are available at MSMS at 517-337-1351

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Workforce Issues Pressure IMGs

Participation in AMA, MSMS the key to future

By Busharat Ahmad, MD

In the next few months, expect increased discussion of and mounting pressure to solve the problems of a projected surplus of physicians in America by proposals to place restrictions on international medical graduates (IMGs). This comes at a time when IMGs continue to be susceptible to summary deselection from managed care plans and find it increasingly difficult to identify reasonable practice opportunities. There is little doubt that the pressure on IMGs will intensify.

A recent report by the Pew Charitable Trust's Health Professions Commission, which called for reducing the number of US medical schools, doctors, nurses and pharmacists, also proposed eliminating Medicare funding of IMG residency positions.

A committee of the Institute of Medicine (IOM) called for an immediate cutback in federally funded residencies, urged that the remaining slots go to US medical school graduates, and proposed special relief for IMG-intensive hospitals. This report did not call for reducing US enrollments or for closing US medical schools.

The Association of American Medical Schools (AAMC) agreed that US medical schools should not be closed. However, their response contended IMGs do not enter underserved rural areas more frequently than do US graduates. The AAMC likely will continue to propose eliminating IMGs from the graduate medical education pool, making slots available only to US graduates.

The government's Council on Graduate Medical Education (COGME) was the first to call for reducing residency positions to 110 percent of 1995 levels. Though the COGME admits to having used flawed figures as a basis for its report, others now propound the percentage reduction theme. To compound matters, the Pew Commission forecasts appear to have incorrectly applied some of the COGME data.

The AMA suggests convening a National Consensus Conference on Physician Workforce to explore all aspects of physicians' future needs and to develop a consensus plan that will achieve a result best for US physicians and their patients. It rebukes the Pew report & IOM suggestions, claiming their ideas don't adequately acknowledge the service IMGs provide to the

population, especially indigent people, or provide feasible ideas to reduce the physician population.

IMG Community Divided

With these pressures, it is little wonder the IMG community is somewhat divided in its reactions. Some agree action must be taken about the rapid increase in the physician population. In the last 20 years, the number of doctors has grown at 1.5 times the rate of the general population. During that same period, some 75 percent of IMGs completed their residency training and entered practice in the US.

Yet many IMGs believe there should be no restrictions placed on residency selection. Two-tiered systems, voucher programs and all other methods of selection that give preference to US medical graduates deny the notion that selection should be determined by merit only to further the quality of US health care. They believe workforce changes should rely on market forces, not quotas or formulae which use guess work as the basis for work force needs projections.

Workforce Planning Essential

It is imperative that a comprehensive study exist which determines future workforce needs. It is not sound policy to base workforce planning on any single issue; the need to balance budgets cannot alone dictate policy.



The author, Busharat Ahmad, MD, stands to address MSMS IMG Section at 1996 Annual Meeting.

Adjustments in the numbers of practicing physicians can conveniently be made at three levels: at medical school, in graduate medical education and through immigration. Funding policies, state licensing practices, and examination requirements can also impact the workforce, but the first three are the most relevant.

The immigration of physicians to the United States should be closely studied and, very possibly, curtailed. Physicians already in training, however, should not become victims of changes in immigration regulations during their residencies. The AMA took a very strong position by stating that if changes in immigration law are necessary, they should not be retroactive. At the same time, loopholes or by-passing of regulations should not be allowed.

We must prevent creation of a "two-tier" system in which IMGs are exploited for service needs. Furthermore, the AMA must continue supporting equal examination requirements for domestic and international medical graduates.

IMG Support Structures

Various support structures exist for IMGs in the US. They are:

The national ethnic medical organizations, created to provide an ethnic identity for IMGs and their families from one specific country.

State, county, and specialty medical society organizations created to serve IMGs. IMG Sections exist in Arizona, Michigan and Wisconsin. IMG Committees and task forces exist in Florida, Georgia, Massachusetts, Missouri, New Jersey, New York, Pennsylvania, Ohio, Texas, Virginia, and Cook (IL) and New York (NY)

counties. An Ethnic Medical Organization Section has been created in California.

The AMA's IMG Advisory Committee, created in 1989, is being replaced by a broaderbased IMG caucus that will include all IMGs who are AMA members and are interested in becoming a member of the Caucus. There will also be an ethnic medical organization membership available within the Caucus.

Each of these structures plays a vital role in highlighting IMG issues and concerns.

IMGs are encouraged to participate in an ethnic medical organization, its activities and programs. State, county and medical specialty society IMG Sections go a step further by making not only the IMG Caucus aware of critical items affecting individuals and the group, but also state legislatures.

The AMA provides the most important advocacy resource that is available to the IMG. Currently, IMG membership comprises just 17 percent of the total AMA membership; greater IMG representation is needed if the AMA is to embrace and advocate their issues.

Clearly, IMGs face issues which could threaten their access to the US medical environment. To combat this, they need to become active participants in organizations which advocate the need for continued IMG presence in the US. Only through these measures will IMGs preserve their roles in serving America's population.

The author is a Monroe ophthalmologist, a member of the AMA Council on Long-Range Planning and Development and the first chair of MSMS International Medical Graduate Section.

The AMA rebukes reports which don't adequately acknowledge the service IMGs provide to the population ... or provide feasible ideas to reduce the physician population.

David H. Janda, MD

A national leader in preventing sports injuries

By Jean Capriotti

ports injury— the all-too-often overlooked aspect of the game. Unless the referee blows the whistle as the quarterback is sprawled on the ground, or the gymnast shocks the crowd by falling off the uneven bars, injury does not take center stage.

When it does become an issue, it is usually after the injury has occurred.

David H. Ianda, MD, director of the Institute for Preventative Sports Medicine in Ann Arbor, is changing the rules of the game and the way in which sports injuries are viewed. Through his research, he has found that with the proper techniques and equipment, many injuries can be eliminated or reduced.

According to Doctor Janda, his institute helps to fill a void in the world of sports. "The vast majority focuses on the rehabilitation of the injury; the other side of the equation is prevention," Doctor Janda explained.

Doctor landa founded the Institute for Preventative Sports Medicine in 1989. In addition to conducting research, he wanted to show the public that sports-related injuries are a major health problem and that the majority of these injuries are worth preventing.

"The public is integral in the move towards preventative sports medicine," Janda claims. "If the public is unaware of the fact that many of these injuries can be prohibited, then who cares? It is the public that can put the pressure on league officials to make changes."

The Institute, a non-profit organization funded mainly by the Catherine McCauley Health System and other grant monies, is the only health care cost containment organization of its kind in North America. Doctor Janda locked onto the prevention aspect of sports medicine simply because he saw through his own experiences that preventive medicine was scarce in the sporting realm.

"As I got more and more involved with research. I found that the focus was mainly on rehabilitation," he said. "There was a helter skelter emphasis on prevention. It was always sidelined."

Doctor Janda, along with a team of eight other physicians, volunteers his time at the institute. The Institute houses test dummies, protective sports gear, and other equipment donated mainly from General Motors. Through Doctor Janda's research results, he is able to determine ways in which sports-related injuries and deaths can be prevented while lowering health care costs.

Doctor landa gained nationwide recognition as the lead researcher on recreational softball injuries. With softball the number one team sport played in America and base-sliding injuries accounting for an average of 71 percent of all recreational softball injuries. Doctor landa saw the opportunity for prevention.

"If we start seeing a predominance of injury patterns, like the sliding-related injuries, we head to the lab and the clinical field stage to develop prevention," he said.

His research showed that when break-away bases were implemented, injuries—from strains to broken bones—are minimized. The Centers for Disease Control and Prevention estimates 1.7 million sliding injuries occur annually, costing more than \$2 billion in treatment. Doctor Janda's study concluded that there is a 96 percent reduction in the number of injuries when break-away bases are used and a 99 percent reduction in health care costs. His study was published in the Journal of the American Medical Association and won the 1989 excellence in research award in epidemiology.

Unfortunately, despite such studies, Doctor Janda and his team of researchers have found that "some of these ideas fall on deaf ears."



Dr. Janda at the Institute for Preventative Sports Medicine in Ann Arbor.

Doctor landa attributes this mind set, that sees professional players as commodities, as the main reason the major leagues do not advocate prevention. "The thought is that injuries will happen but they will happen to the opposing team's players," said Doctor Janda.

The Institute has an Advisory Council comprised of leaders from amateur and professional sports as well as from business and the community. Retired players, said Doctor Janda, are the ones who are the most receptive to prevention because many of them have experienced complications associated with sports related injuries.

Doctor Janda's work stretches well beyond the walls of the Institute. In addition to being a clinical orthopedic surgeon at Doctor Janda sits on various councils. He was appointed by the Bush Administration to the Board of the National Center for Injury Prevention and Control. Other appointments include the National Institute of Health's Trauma Task Force and an appointment to Governor John Engler's Council on Health, Fitness and Sports for the State of Michigan. His most recent appointment was to the National Football League Players Association to oversee and review injuries.

Doctor Janda and the Institute for Preventative Sports Medicine not only have gained local and national attention, with appearances on the Today show and CBS This Morning and in front of the US House Appropriations Subcommittee on Labor Education and Health and Human Services, but international acclaim, as well. He has traveled to Canada, Europe and Australia to speak to their governments on preventative sports medicine. When presenting outside of the United States, the focus is on past research and experiences.

"One of the things we bring to the table is what we have already done that has failed so that mistakes aren't duplicated," Doctor Janda explained.

Doctor Janda has been the recipient of the clinical research award by the American Orthopedic Society of Sports Medicine, and the Canadian Academy of Sports Medicine. The American Academy of Orthopedic Surgeons has recognized him for his video presentations and research.

Doctor landa will not take sole credit for any of these accomplishments, noting that "an organization does not succeed because of one person."

While pleased with the impact the Institute has made, Doctor Janda acknowledges that his work is not completed.

"Our mission is over when everyone is aware of the benefits, both medical and economical, associated with prevention and changes are made to assure these benefits are made possible," he said. "Prevention has everything to do with health care reform. It's not a bang for the buck, it's a sonic boom for the buck."

The author is an MSMS staff writer.

"Prevention has everything to do with health care reform. It's not a bana for the buck. it's a sonic boom for the buck."

Valuing physician practices

Michigan Medical Advantage helps physicians know their worth

By Kenneth M. Hekman, MBA, FACMPE

n December 1995, the American Medical News reported that 36 percent of hospitals have bought medical practices during the last five years. But only 17 percent of the hospitals that acquired practices reported generating positive returns on their investments. What went wrong? How can integrated health systems hope to deliver care more efficiently in the face of persistent losses?

The threats and opportunities of managed care are reshaping the medical practice landscape in most communities throughout the country. The urge to survive and remain competitive has brought many physicians to the threshold of selling their practices or merging with others. Hospitals and health plans are competing for physicians' interest along with enterprising physician groups. The projected growth of investor-owned physician management companies will likely make an already active market even more interesting.

Physicians who face the possibility of selling or merging have a host of decisions before them. Perhaps the most fundamental interest-preserving question that begs a logical and fair answer is this, "What is my practice worth?"

History of Practice Valuations

In less competitive markets of the past, the answer to that question was relatively simple. Friendly transactions involving new partners in a small group practice were usually limited to buying into depreciated equipment and a portion of the accounts receivable. The value was derived from the balance sheet by the group's accountant and the agreements were drafted by the group's attorney. The environment was characterized by trust developed by working together for a year or two before the buy-in was formalized.

The case of retiring physicians may have been slightly different, but equally simple. Goodwill values may have been expected in addition to fair market values for equipment, but the method for determining goodwill was usually a rule of thumb found in the literature, without consideration for circumstances that may increase or decrease the value of the practice in comparison to peers.

That's all changing now. Competition for certain special-

ties has escalated the market value of some practices, and the mixture of incentives and motives has added dimensions to the transaction decision that were unheard of a few years ago.

Primary care practices have become the darlings of the market as their gatekeeper role has gained prominence. Some hospital executives and others see family physicians as the "currency of the future." Those physicians closest to the entry point for medical care are viewed as highly valuable because of their enormous influence on other services the patient may require. By contrast, super-specialists who are reliant on referrals may face unprecedented volatility in their income streams, making their practices worth less on the open market than they may have hoped for under former conditions.

Determining Value

Physicians preparing to explore their options for integration are well-advised to get an independent appraisal of the value of their practice, and to work toward increasing the practice's fullest value before selling or merging. An independent appraisal can be secured from specially trained consultants who blend financial analysis with professional judgment to derive a defensible conclusion about the business value of the practice.

Appraisers generally take three approaches to the assignment of determining the value of a business. They first look at the underlying hard

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assets such as equipment, accounts receivable and prepaid obligations like professional liabilities premiums paid in advance. Items such as accounts receivable may not appear on the official balance sheet of the practice if it is operated as a cash-basis business, but the appraiser must prepare an adjusted balance sheet to reflect the collectable value of receivables. Other adjustments might be made for the fair market value of equipment that is still useful even though it is fully depreciated, and for liabilities such as loans to the owners. After all adjustments have been made, the appraiser's conclusion of the equity becomes a foundation for understanding the other components of value.

The second approach to valuation is to examine the revenue stream, and to determine the future benefit of the revenue stream to the prospective new owner. This approach may involve several valuation techniques that look backward as much as five years. This so-called "income approach" focuses on more than simple revenues. It must examine the profitability of the practice compared to others in its specialty. Some appraisers focus only on the "excess physician discretionary income," the portion of compensation and benefits that are above the median for the specialty. Their premise is that the future value of the business lies in the profits that are above average.

The third approach is to compare its characteristics to others that recently became acquired under similar circumstances. This "market approach" is most similar to the technique widely used in valuing real property. Real estate appraisers offer opinions about the value of a house based on prices of known transactions of similar houses in the neighborhood. The market values of medical practices are less widely publicized, but databases from national sources are used by skilled appraisers.

Choosing an Appraiser

The first characteristic to look for is that an appraiser is capable of making an independent judgment about the fair market value. Skilled appraisers understand the importance of weighing financial circumstances with the expectations of the buyer and seller to conclude a fair price. The elusive middle ground is the goal. Fair market value is defined by the IRS as "the price at which the property would change hands between a willing buyer and a willing seller when the former is not under compulsion to buy and the latter is not under compulsion to sell, both parties having reasonable knowledge of relevant facts." (revenue Ruling 59-60)

The second requirement is that the appraiser follows the Uniform Standards of Professional Appraisal Practice of The Appraisal Foundation. The foundation is the foremost standard-setting organization in the appraisal discipline, and its members must commit to staying informed of, and following, the uniform standards to assure highly professional quality.

Appraisers that understand physician practices are more likely to appreciate the nuances that lend value to the business.. Many appraisers approach medical practice valuation as they approach any other small business assignment, and miss the characteristics that set the practice apart from its peers.

Integration dynamics may drive physicians together, sometimes against their will. But physicians' interests can be protected through wise decision-making at the time of the transaction. An independent appraisal is an ideal tool physicians can use to protect their interests in a volatile time.

The author is president of Hekman & Associates, and a consultant for Michigan Medical Advantage. He can be reached at 517-336-1400

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MEDICAID CAPITATION



Michigan Physicians Prepare for Change

William E. Hill, MD, has already felt the effects of Michigan's pending move, planned to begin in winter 1997, to a fully capitated Medicaid system. The Pontiac OBGYN, whose practice is roughly 50 percent Medicaid, has made a career of treating the poor. Yet his experiences of the past year have left Doctor Hill worried that his solo practice will be sucked under in the groundswell of HMOs positioning themselves to be in front for Medicaid contracts when bidding starts.

What can doctors expect as the state implements a capitated system? Is it imperative that physicians sign-up now with contractors to maintain patients? As Michigan adopts a fully capitated Medicaid program, Michigan physicians have experienced confusion, apprehension and misinformation. In founding Michigan Medical Advantage, MSMS offers practical support to affected physicians weighing contract offers. The message is to "take your time," and "use MSMS aand MMA." Here, Michigan Medicine takes a look at facts and fiction surrounding Michigan's move to managed care—and how physicians can take control.

by Karen Bouffard

Continued on following page

Medicaid Capitation

Michigan Physicians Prepare for Change

Continued from previous page

"HMOs have come in and —through devious means—taken my patients," says Doctor Hill, MD, Flint, adding he's already lost a portion of his Medicaid patient base. "Some patients were led to believe they could continue to see me here in the clinic, when they could not. Or they told patients they would lose their insurance with Medicaid if they didn't sign up.

"They've approached them in their homes, at grocery stores or outside Social Service offices. Their recruiting practices have been very, very unethical all along."

MSMS, aware of physicians' concerns, has worked closely in this transition period with the Medicaid administration and doctors also to re-

> duce physicians' concerns regarding proposed changes. "Medicaid has sought MSMS advice on how the changes should be implemented and has requested MSMS input regarding the new program," says Krishna K. Sawhney, MD, chair, MSMS Board of Directors.

> In response to vigorous complaints by Dr. Hill and others, the State Legislature has included language in the Department of Community

Health budget — Senate Bill 847— prohibiting Medicaid capitated health plans from directly marketing to or enrolling Medicaid-eligible patients.

But with the focus shifted toward marketing physicians, many doctors say they've been the target of misleading advertisements and scare tactics designed to get them on-board with capitated health plans before they've had a chance to review their options.

Doctor Wilhelm



Facts and Fiction

According to Daniel J. Wilhelm, MD, a Port Huron pediatrician and chair of the MSMS Medicaid Liaison Committee, Michigan's move to a fully capitated Medicaid program is the result of simple economics.

"The State wanted to cap the rate of increasing Medicaid costs, and they saw that the Physician Sponsor Plan could save 12 to 15 percent over fee-for-service," he says of PSP, which provides physicians with a \$3 monthly per-patient case management fee and a fee-for-service reimbursement. While not officially discontinued, the plan will be made obsolete with the move to managed care. "Then they saw that HMOs could save another 12 to 15 percent over

Michigan has first opened up this full-risk, competitively bid, managed-care system in the Southeastern Michigan Counties of Wayne, Macomb, Oakland, Washtenaw and Genesee. The program later will be adopted throughout the state. In addition to HMOs, physician- and hospital-based entities may bid for the contracts, providing they meet the same standards as HMOs with regard to accreditation, and other requirements contained in state laws, administrative rules and department policy.

Michigan has organized its managed care initiative into three health plans and two service carve-outs: The Comprehensive Health Care Plan, which will provide service for most low income people; the Children's Special Health Care Services Plan (CSHCS), which includes Medicaid funding for comprehensive health care and state funds for specialty Medicaid services for Title V children with special health care needs; the Long Term Care Plan (LTC), providing acute health care services, long term care in nursing facilities, and community based alternatives to nursing facilities for people requiring long term care; the Behavioral Health Services Carve-Out, offering mental health services; and the Developmental Disabilities Ser-

Doctor Barnes

vices Carve-Out, offering specialized developmental disabilities services.

According to Department of Community Health documents, Requests For Proposals (RFPs) will be released early this Winter for the Comprehensive Health Plan and

Children's Special Health Care Plan.

An RFP will likely be released for the Long Term Care Plan in mid-1997. Competitive bidding and models for full integration of primary health care and Behavioral Health Services will be introduced in October 1998. For the Developmental Disabilities Service Carve-Out, competitive bidding will begin in October 1998; models integrating health care and specialized developmental disabilities services will also be tested.

According to Doctor Wilhelm, there has been some "untruthful advertising, especially in the Detroit area" about the process.

"Some of these HMOs have contacted doctors and implied that there's a deadline to sign up or they'll lose their patients," he says, noting that he personally has received misleading solicitations through the mail. About 25 percent of Doctor Wilhelm's patients are Medicaid recipients, he says, and during hard economic times that portion of his practice has reached 35 per cent. "HMOs want to sign up as many as they can, because the more Medicaid patients they can deliver the more likely they are to get the bid.

"(Claims that there is a deadline) are not true," he adds. "Doctors will have the choice, and can wait and see which players are in the ballgame and which they want to sign up with."

Doctor Sawhney agrees that physicians have enough time to review their options before signing with an HMO. MSMS has arranged for Medicaid officials to visit physicians around the state to explain the process and to try to allay doctors' concerns about continuity and quality of care.

The RFP, he says, gives bidders 75 days, or until January 31, to respond. After responses are received, the state will take two months to review proposals before conducting readiness review or site visits.

"Then," he adds, "once contracts are signed it could take another three months to transition people — to actually get them into the computer and a new card issued."

While Doctor Sawhney says that pending legislation prohibiting direct patient marketing provides "a little more control" for physicians, he adds that some HMOs are using misleading marketing techniques.

A recent advertisement on the back page of Healthcare Weekly Review, for example, is headlined, "PSP Physicians: Time is Running Out!" The text reads, "The Department of Community Health will be ending the PSP program soon in five southeast Michigan counties. If you do not choose a managed care plan, your Medicaid patients may be reassigned to a physician who is part of an approved plan." The ad also states the plan is "Certified by the Michigan Department of Community Health for Medicaid Managed Care."

According to Bradley T. Barnes, MD, a Rochester Hills pediatrician and member of the MSMS Medicaid Liaison Committee, "A lot of plans would like to have physicians think they have to transfer their patients by January 1, but that's not true."

He adds, "It's in the HMO's best interest not to have everybody informed, so that doctors panic and sign up with anybody they can so that they don't lose their patient base. The plans tend to encourage that fear, because they'd like to get people to commit to them, and sign on, and turn all their Medicaid patients over to them."

Doctor Barnes notes that the new system is designed to allow competition among numer-

Some of these HMOs have contacted doctors and implied that there is a deadline to sign up or they'll lose their patients... (Claims that there is a deadline) are not true. - Daniel J. Wilhelm, MD, Port Huron

Patients who have (HMO) cards have no idea why they can't see me. The worst part is that they don't know who to call or who to see... They're assigned to various clinic plans, and I have no idea where to send them. - William E. Hill, MD, ous plans — a reason for physicians not to panic.

"There's not going to be a single contractor in an area," he says. "Everybody who puts in a bid, and covers their benefits package equitably, and has a reasonable benefits package will be approved."

Ready or Not

According to a Public Sector Consultants report, at present 61 per cent of Michigan Medicaid beneficiaries are enrolled in the Physician Sponsor Plan, 33 per cent in HMOs and the remaining five per cent in the Medicaid Clinic Plan, a capitated plan for ambulatory services. Doctor Hill's experiences with HMO-enrolled Medicaid patients have been disturbing.

"Patients who have (HMO) cards have no idea why they can't see me," Doctor Hill says. "The worst part is that they don't know who to call or who to see. They don't know who their primary care physician is. They're assigned to various clinic plans, and I have no idea where to send them. I have to say 'Call your case manager."

Doctor Wilhelm says he thinks the state has moved too swiftly.

"I'm concerned that they do not have an information system in place to track, and to allow patients to select their doctor. Their system isn't sophisticated enough to allow a good match between patient and doctor."

Doctor Wilhelm adds the information system isn't able to match a patient with a doctor by age. "This is very basic," the pediatrician says. "If you have a population of children, you want to make sure they're matched with pediatricians. I've had to close open-enrollment to Medicaid. Otherwise, I would have had grandmas banging on the door."

Doctor Sawhney shares Doctor Wilhelm's concerns about the readiness of the current system to make the change. "To my knowledge, the state hasn't done any location studies or geographic studies to show where the physicians are compared to where the patients are." He adds, "We do question whether they are ready to fully implement the new system."

Quality and Equity

While many Michigan physicians view the move toward managed care as not only inevitable but necessary, many also harbor doubts about whether quality and equity can be preserved under a managed care system.

According to Doctor Wilhelm, the move to managed care "is an opportunity to take away the stigma of being a Medicaid patient" because plans will issue cards to Medicaid recipients that are indistinguishable from those issued to other plan members.

Likewise, Doctor Barnes notes that under the new system Medicaid recipients will become "transparent" to health care providers that are paid equally for Medicaid and non-Medicaid patients.

Because beneficiaries can choose among many plans, Doctor Wilhelm believes the new system may improve access for some patients. Doctor Barnes adds that, because physicians can sign up for as many plans as they wish, more doctors will be able to participate with Medicaid — resulting in more choice for patients.

Adds Doctor Wilhelm, "I'm thoroughly convinced that this group (Medicaid beneficiaries) needs to have their care managed. It's an opportunity not only to treat but to educate about what can be done to keep them healthy."

Despite these positives, many doctors' experiences with capitated health plans have left them wary of what could lie ahead. One of these is Escanaba Neurologist Janelle L. Cooper, MD, who views her experiences with capitation of mental health services as foretelling.

"Right now, mental health services for Medicaid are really capitated services because the state gives money to the community mental health boards, which make the decisions," says Doctor Cooper.

Pontiac



Doctor Cooper with patient in her office.

"I have a psychiatrist, psychologist and social worker in my practice, but my community health board refuses to pay for psychiatric or psychological services," Doctor Cooper says. "Most of these patients go without any kind of mental health treatment. Some of them we end up seeing for free. There's supposedly a request system in place, but we've never gotten approved for a single patient."

Doctor Cooper says the county doesn't approve payment for mental health services because the county itself offers psychiatric and psychological treatment for Medicaid recipients.

"There is a part-time psychiatrist, one fully licensed psychologist and the majority are social workers or caseworkers," she says of the county's program. "For a population of about 75.000 that's absolutely inadequate. There's a three month wait to see a psychiatrist."

Doctor Cooper adds, "I'm worried that the kind of difficulty I'm having with just the mental health portion is going to start affecting me in the rest of my practice — because this is just a microcosm of what's going to happen with a fully capitated system. It's really quite grim."

Other physicians are concerned about entities, previously uninterested in Medicaid patients, which have scrambled to sign up patients and physicians.

"Here is a population that nobody wanted, and all of a sudden they're a hot item," says Doctor Hill. "It's the entrepreneurs out there that stand to make a killing from the state."

He adds, "Medical coverage is not the same as medical care."

According to Doctor Barnes, "The economics of Medicaid are that they've always paid doctors so poorly, and yet now all of these HMOs want to get into it — so there must be some money somewhere."

Doctor Barnes adds that with good managed care, medical costs can be reduced by cutting down on hospitalizations. Yet, he adds, "Savings they've been able to manage by saving on hospitalizations are going to come to an end. There's a point beyond which you can't go and still provide good care — so profitability will diminish."

Ms. Shearer is concerned profits could come from patients who don't utilize services, due to problems of access.

"There's going to be an access problem with these HMOs," she says. "Not all of (Medicaid recipients) read. They're not at the same address for long. They don't have access to transportation."

Based on his experience, Doctor Hill also is concerned about issues of access. "People with no transportation are signed up with (HMOs) five or six miles away, and no way to get there," he says.

According to Doctor Barnes, bidders will have to provide "wrap-around" services such as transportation and home care, in order to qualify. In addition, at least 25 per cent of an entities' patient base must be non-Medicaid a measure that will deter organizations from setting up "Medicaid Mills."

A Department of Community Services document states that "All Qualified Health Plans will

Because physicians can sign up for as many plans as they wish, more doctors will be able to participate with Medicaidresulting in more choice for patients. -Bradley T. Barnes, MD, Rochester Hills



receive supplemental funds for nonemergency transportation where it is determined to be necessary so that enrollees can secure appropriate care." The Department Community Health budget also stipulates that Medicaid capitated health plans establish an ongoing internal quality assurance program for health care services that includes data collection, outcomes measurement and other requirements. In addition, the

legislature has included language in the Department of Community Health budget mandating quality control measures. Included are a prohibition on state contracts with entities that impose gag rules in their relationships with health care providers, and a provision requiring the Department of Community Health to contract only with providers that cover a minimum length of postpartum hospital stay of 48 hours for a vaginal delivery and 96 hours for a cesarean delivery.

Yet Doctor Barnes is concerned about the appropriateness of allowing for-profit entities "to take profit out of the Medicaid budget when there's still so many uninsured people.

"These plans will make a profit off their Medicaid patients," he says, "and it's bothersome to me that they'll be able to take money out of the system — when they're not providers, they're just stockholders — leaving an uninsured population still vulnerable."

Taking Control

Vivian Lewis, MD, a Flint pediatrician who handles 600 Medicaid patients, is not panicking. She's counting on her large patient base and numerous affiliations to soften the impact of the change to capitated care.

"There will be three or four different HMO situations that will give the patients more variety in signing up," she says. "How (the move to managed care) affects me will depend on whether any of the organizations I'm affiliated with gets a bid. If they don't, I could lose those patients. But I doubt that will happen.

"(HMOs) aren't bringing physicians into the community," she adds. "They're working with the doctors that are already here."

Doctor Lewis is working with her hospital's PHO to benefit from strength in numbers. "The Hurley Medical Center PHO has been working with local HMOs to present themselves as an umbrella organization," she says. "They will do the enlisting, and patients could choose any one of those physicians."

Adding a note of caution, she says, "(The benefits of physicians working with PHOs)depend on how balanced the relationship is between the PHO and the hospital. I'm afraid physicians could lose out as partners and be more like employees."

Doctor Cooper is on the Board of Directors of the Upper Peninsula Physician Network. "We're putting together a physician-designed managed care plan that would be a competitive vehicle for (Medicaid) contracts," she says.

Michigan Medical Advantage is currently analyzing several models for involvement in the Medicaid program. The MSO can also assist physicians with services such as analyzing and negotiating contracts; negotiating and managing capitated payment agreements; and arranging capitation stop loss coverage for capitated contracts.

"(Michigan Medical Advantage) may be able to put together a bid where doctors are in charge and could have some say about what direction things go in," says Doctor Barnes. "I'd certainly want to transfer my patients to the Society organization where I could be assured that profits would be used appropriately.

"Basically, managed care has a lot to say for itself if it's done correctly with patients' best interests in mind," Doctor Barnes adds. "PSP was a start, but didn't go far enough. So the move toward HMOs is good — as long as the purpose of the organization that takes it over is patient service, and not profit."

The author is a Williamston based freelance writer.

The legislature has included language in the Department Community Health budget mandating quality control

measures.

Restructuring Michigan Health Care

State to Seek Input From Providers, Consumers and advocates

By Robert Smedes

The establishment of the Michigan Department of Community Health (MDCH) is the result of our conviction that state healthcare policy needs to be more coordinated and integrated, that spiraling health care costs must be controlled, and that the access and quality of health care services for Michigan's vulnerable citizens must be improved.

Towards this end, the MDCH has adopted an aggressive, statewide managed care approach for publicly funded health care services. The new Department of Community Health must be a more aggressive purchaser of cost effective, high quality services in the health care market. In addition to these goals the consumers of our health care services must be satisfied with the product they have purchased.

A key component of this new purchasing strategy is that managed care organizations will be invited to competitively bid to provide services to eligible consumers. The health plans that provide the best value for the best price will be selected to participate. All of the successful bidders, called "qualified health plans", will be held accountable for the delivery of quality services and measurable outcomes. This will be performed through routine contract performance monitoring.

The Department's change in the purchasing and delivery of state funded health care will be carried out as follows:

The Comprehensive Health Care Plan will provide health services for most low-income persons who have participated in the traditional Medicaid Program. A Request for Proposal (RFP) has been released detailing the services the State intends to purchase from qualified health plans to serve Wayne, Oakland, Macomb, Genesee and Washtenaw counties. It is our intent to determine the successful bidders in early 1997, with enrollment of Medicaid clients for services beginning in spring of 1997. A second RFP will be released in 1997 to implement this plan in the remaining Michigan counties. The Comprehensive Health Care Plan will be implemented statewide in January 1998.

The Children's Special Health Care Services Plan (CSHCS) includes State and

Federal funding for comprehensive health care for specialty services to children with special health care needs. This RFP was released simultaneously with the Comprehensive Health Care Plan RFP and details the services that the MDCH intends to purchase from qualified health plans throughout the state. Voluntary enrollment of the CSHCS families is likely to begin in the spring of 1997, following the selection of successful bidders. This plan will use a "case rate reimbursement methodology" to pay the qualified health plans.

The Long Term Care (LTC) Plan will include acute health care services, long-term care services in traditional nursing facilities, and home and community based alternatives to nursing facilities for all persons requiring long term care services. A planning document entitled, "Call for Ideas" has been released this fall which asks for provider, advocate, patient, and family input on how to restructure health care delivery for patients in need of long term care. An RFP will be issued in 1997 for the selection of qualified healthcare plans to administer these comprehensive health services. Enrollment into these plans is expected to begin in early 1998.

The Managed Care Carve Out for Persons with Developmental Disabilities - beginning in October 1996, the State began a transition in the financing and management of publicly financed health care services, including the funding of specialized services for persons with developmental disabilities. Initially, the

through Michigan's Community Mental Health system, with competition among providers and or managers introduced in the later phases of the plan. Flexibility in service\support planning and delivery will be incorporated to the greatest extent possible given federal regulations. Shared a significant component of this carve out. It is expected that this carve out will be phased in over a three year time frame. Extreme care will be taken to ensure that recipient's rights are protected, and that services\supports are of high quality and responsive to the needs and desire of the consumer. A concept paper and request for comments was distributed in November.

Health - This proposed carve out consolidates In FY-1998 the Department will invite both

specialized services will continue to be managed public funding for Behavioral Health services. State general funds, federal block grants and traditional Medicaid moneys will be pooled together and the funds will be managed initially by and through the local community mental health boards (CMHB). These specialty service dollars will be carved out of the Comprehensive risk with the selected providers will also become Health Care Plan. During FY-1997 the combined moneys will be administered, by contract, through the local community mental health board. This particular plan covers both the Medicaid population and the low-income, non-insured population. It is hoped that this plan will develop the capacity of the local CMHBs to accept full risk and also eliminate all waiting lists for behavioral health services The Managed Care Carve Out for Behavioral (all mental health and substance abuse services).

private and public organizations to service, any willing provider" method of competitively bid to deliver these services. This reimbursement, to competitive bidding for fully carve out also will call for piloting health care at risk, capitated plans administered through delivery models that integrate primary care with qualified health plans, it is imperative that behavioral health care. The carve out will also explore innovative organizational structures and financing mechanisms, in particular, in the area of substance abuse services. A concept paper and request for comments will be released in input from the entire healthcare industry. December. In January, a number of regional forums will be held to collect information and share ideas with consumers, advocates, and providers.

The Department truly realizes that the success or failure of it's new health care The author is chief executive officer of the Medical initiatives resides with the State's health care Services Administration, Michigan Department of providers, in particular, it's physicians. Because the state will be moving away from the "fee for

individual physicians begin to network with existing HMO's, Clinic Plans and qualified health plans that will be bidding for these services. It is our intention to continue to solicit consumers and advocates during the developmental and implementation phases of these massive changes in the delivery of health care to Michigan's residents.

Community Health.

The Department truly realizes that the success or failure of its new health care initiatives resides with the State's health care providers, in particular, its physicians.

Medicaid Administration's Communication and Enrollment Strategy

Phase 1-Torget Group:

81 PSP providers with more than 500 Medicaid recipients. Includes individual letters explaining the status of the program changes and providing a fact sheet for providers' questions as well as questions their patients may have. Also includes a persona phone contact from an MSA representative offering assistance regarding the program changes, current capitated plans in their area, recipient enrollment questions and billing questions.

Ande II- Poct-Company

16) PSP providers with between 200-500 recipients. Includes a personal letter with fact sheet a personal phone call and the offer of a personal visit determined by the needs presented by the provider.

197 PSP providers with 100 or less recipients. Continue the approach that works. Assumes that by this time, many of these providers will already be affiliated with a capitated plan.

Community and Semiliar

Also includes a regular written communication to all PSP providers and other interested parties during the transition to the Qualified Health Plan approach. This could take the form of a newsletter and be a regular source of information on the status of all Plans under development. This communication would answer many of the questions and letters MSA is receiving to while providing a positive customer service to providers.

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From PSP to Capitation

MSMS Advocates for Members Caught in Medicaid Changes

By Mary Anne Ford

n November 18, the Michigan Department of Community Health released its long awaited request for proposals, seeking qualified health plans to contract to provide services for Medicaid patients on a capitated basis. The contracts awarded during 1997 will extend through December 31, 1998. Currently, the Department is seeking bids in Wayne, Oakland, Macomb, Genesee and Washtenaw Counties. Separate RFPs will be issued late next year for all other counties in Michigan for a capitated initiative to begin in January, 1998.

The current initiative will phase out the Physician Sponsor Plan for 175,000 Medicaid patients in the five-county area; they will be enrolled with qualified plans. An additional 300,000 patients are currently in capitated programs—some of these patients may enroll in new plans or be reassigned.

Responses to the RFP are due to the Michigan Department of Community Health by January 31, 1997. Patient enrollment will begin following review and selection of qualified health plans by the department.

A complete summary of the RFP is available on MSMSNet and upon request from MSMS. An important issue in MSMS discussion of the Medicaid initiative has been the potential role for Michigan Medical Advantage, the management services organization of MSMS.

Michigan Medical Advantage is undertaking a careful analysis of the Medicaid RFP to examine both the potential of MMA to submit a proposal to be a qualified health plan, and the needs for new services generated by the new initiative. Although the RFP clearly indicates that provider sponsored networks can submit proposals, it also indicates that submission of a proposal is considered an initial application for licensure as an HMO. Since HMO licensure would be a significant departure from the goals and mission of Michigan Medical Advantage,

it is unlikely that MMA will be able to submit a proposal. Instead, Michigan Medical Advantage will focus efforts on providing tools for physicians and physician organization that are evaluating contractual arrangements with plans that are submitting proposals; or who are contemplaintg submitting a bid themselves.

The Medicaid Capitation Initiative

Announcement by the Michigan Medicaid program that the program will move to full risk capitation early in 1997 left many physicians concerned about the ability of their groups to manage Medicaid risk contracts. Of the 475,000 Medicaid patients currently in Wayne, Oakland, Macomb, Washtenaw and Genesee Counties. 175,000 are enrolled in the Physician Sponsor Plan. A significant number of physicians who are currently providing services to PSP enrolled patients are not affiliated with any group. These physicians, and their patients, feel particularly vulnerable to the pending changes.

Adding to the concern is the uncertainty about how and when Medicaid capitation will be implemented.

At this time, we know that Medicaid plans to select qualified health plans to accept full risk contracts through a competitive bidding process. While qualified health plans will be expected to meet many of the financial, governance and administrative standards required for licensed HMOs, Medicaid officials are encouraging bids from provider sponsored networks that can meet these specifications. This means that a well-organized physician group could submit a bid, although the administrative requirements leave many wondering if they can.

Medicaid will choose qualified health plans which meet specifications for assuring quality



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and access and which propose a capitation rate within a corridor defined by Medicaid. Some criteria will screen out bidders who are not qualified; points will be awarded for others. Once plans are chosen, Medicaid patients will have the option of choosing a plan; those patients who don't choose a plan will be assigned by the Department. The assignment process is likely to give preference to those plans with the highest scores on their bid, including scores related to pricing.

There are no plans for "exclusive" contracts with qualified health plans; Medicaid will contract with all bidders that meet criteria defined in the request for proposals.

MSMS Information and Advocacy

When Medicaid announced plans for its capitation initiative, MSMS quickly arranged briefings for physicians in affected counties. Robert Smedes, chief executive officer of the Medical Services Administration within the Michigan Department of Community Health, participated in six briefings for PSP physicians, PO and group practice leaders and medical group managers to describe the planned changes, the role for physician-directed networks, and the potential impact on physicians and patients.

Smedes also offered a unique opportunity for MSMS and other health organizations to review an early draft of the Request for Proposals and offer comments. This review, together with many meetings between MSMS leaders and staff and the Michigan Department of Community Health, provided MSMS with the opportunity to identify several issues that would be critical to assure the ability of a physician directed networks to bid on the proposal, and to assure as smooth a transition as possible.

Issues raised in discussions between MSMS and the Michigan Department of Community Health have included:

- the need for Medicaid data to be made available to provide a base for determining whether a network is able to bid.
- the need for Medicaid assistance in linking bidders to hospitals; Medicaid officials have indicated the potential availability of currently participating hospitals at Medicaid rates, with a premium paid to Medicaid.
- the need for protections for patients and physicians against unscrupulous market-

The Timetable for Physician Action

November 26-MSMS leaders decide whether to recommend Society bid for Medicaid contract and form required HMO structure.

January 31—Bids are due to State of Michigan for Medicaid care delivery in Wayne, Oakland, Genesee and Washtenaw counties. April 3—MDCH recommends awarding of contracts.

Spring—Enrollment of Medicaid clients be-

July—Medicaid clients in computer and new cards issued. By now, physicians must have chosen to contract with a plan to provide care. 1997—Second RFP goes out to remaining

1998—Medicaid comprehensive Health Care Plan is implemented statewide.

ing practices. - strategies for informing patients about the changes and for minimizing disruption of existing physician/ patient relationships.

the need for adjustments to capitation rates for physicians who see a large number of severely ill, high-cost patients.

Medicaid officials have been receptive to many of our concerns.

As news about Medicaid plans to contract with qualified health plans was released, many plans and hospitals immediately began efforts to enroll physicians in their plans. Many physicians contacted MSMS with concerns about the misleading information they were receiving from plans, prompting MSMS to mail information to all members. Some points from that mailing are worth reemphasizing:

- No plan will have an exclusive contract -Medicaid plans to contract with all plans meeting the criteria that will be specified in the request for proposals.
- As with any contract, physicians should carefully examine details of any agreements with health plans for care of Medicaid patients.
- Health plans no longer will be able to market directly to patients, therefore, they are marketing through participating physicians, and will rely on your established Medicaid patients.

Michigan Medical Advantage

Michigan Medical Advantage (MMA), the management services organization of the Michigan State Medical Society, can assist physicians in the transition to the Medicaid capitation system. MSMS is considering carefully the role Michigan Medical Advantage should play in this transition.

Many physicians are encouraging MMA to submit a bid for the Medicaid contract, which would mean that MMA would share risk for the Medicaid patients it enrolls. Although this would represent an excellent opportunity for physicians, it does represent a departure from the goals of the MSO as originally directed by the society's House of Delegates. The Medicaid proposal was not a factor in the deliberations of the House. which directed development of a management services organization to provide managed care management services to physicians.

In an all member mailing issued in September, MSMS leaders urged members to exercise caution with respect to signing contracts for Medicaid capitated plans. We expect the release of the RFP to bring new pressures on physicians currently participating in the Physician Sponsor Plan, as one criterion for qualification in-

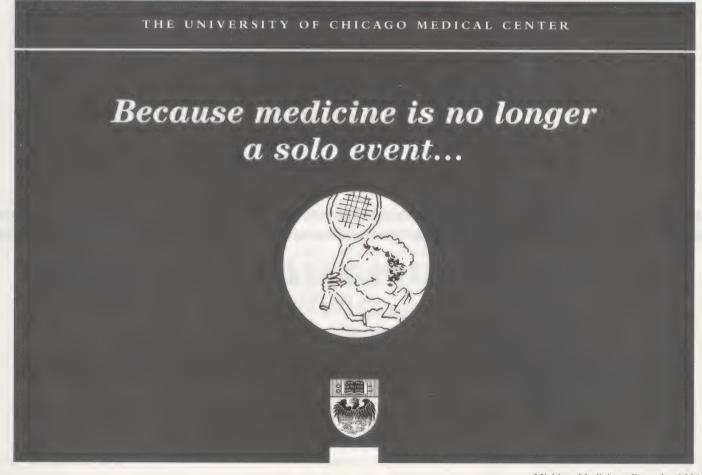
cludes participation of current PSP physicians. Physicians are reminded to conduct due diligence before signing any contract. Michigan Medical Advantage can provide services to help physicians with contract review, PO development, group development and capitation review and analysis.

Michigan Medical Advantage also can help organized physician groups develop proposals to become a qualified health plan. Qualified plans will be required to meet criteria relating to financial stability, utilization management, quality assurance, member services, claims adjudication and data reporting. All of these functions require significant expertise and infrastructure and many Michigan Medical Advantage can assist in providing these functions, or in evaluating vendors. Contact Kevin Cawley at Michigan Medical Advantage at (517)336-1400 for more information.

For information on the Medicaid initiative and next steps for physicians, contact Mary Anne Ford at MSMS at (517)335-5721. ■

Ms. Ford is manager, MSMS Department of Medical Economics and Health Care Delivery.

No plan will have an exclusive contract-Medicaid plans to contract with all plans meeting the criteria that are specified in the RFP.



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Timothy C. Fabian, M.D., F.A.C.S., Professor and Deputy Chairman of Surgery, Director of Trauma, University of Tennessee at Memphis, Memphis, TN LECTURE: Difficult Abdominal Wound Closure

Constantine P. Karakousis, M.D., Ph.D., Chief, Soft Tissue-Melanoma, Professor of Surgery, State University of New York at Buffalo, Director, Surgical Oncology, Millard Fillmore Hospital, Buffalo, NY

LECTURE: Current Management of Malignant Melanoma

David Wisner, M.D., Professor of Surgery and Cheif of Trauma, University of California, Davis Medical Center, Sacramento, CA

LECTURE: New Approaches to the Initial Management of the Trauma Patient

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Young fathers need role models

Physicians and others provide guidance for mentoring program

By William Kendy

It's not easy being a first time parent. It's a joyous and stressful time when, as Roger Gerstle, MD, a Traverse City family physician notes, first time mothers and fathers need all the help and support they can get.

Doctor Gerstle, a private practice family physician who also works at Munson Medical Center Family Practice Center, administers to a significant number of pregnant teens during his daily routine. While at work, Doctor Gerstle has observed that both the numbers of fathers involved in the prenatal process and the support groups for these men is minimal. "Everything is aimed at the woman as the primary care giver. The dad gets no support and recognition as an active and equal care giver," noted Doctor Gerstle.

To remedy this, Doctor Gerstle began to research options available for young men and, during the process, came across the Doula program.

The Doula program, founded in 1975, is based on the idea that all new parents can benefit from assistance of some kind in order to understand the changes that occur in the family. The word "Doula" comes from a Greek work that describes a woman who helps and supports another woman during pregnancy, birth and the first three years of her child's life. While Doula's services have always been available for first time fathers, only a small number of men have been involved. However, the Doula program of Traverse City is hoping to change all that with the introduction of a pilot program called the Young Father Mentor Program.

"Our ultimate goal is to get fathers more involved with their children's lives and help them reach more of their personal and professional goals," said Ms. Scruffie Crockett, Doula Program Director.

As one of the first supporters of the program, Doctor Gerstle hopes to work towards alleviating problems generated by long work commutes and busy schedules in order to create an environment in which dads are "more active in the prenatal and postnatal treatments." He advocates programs and

policies which take important step towards this.

"In many cases, the dad can't accompany the mother to an ultrasound simply because he can't get off work or can't afford to take the time off," said Doctor Gerstle. "And after the baby is born, if we can get the fathers to participate in the office visits, I think that a physician can become somewhat of a role model for them. Just watching a male physician hold a newborn, or quickly change a diaper can show dads that it is o.k. to be involved."

Doctor Gerstle adds that allowing men to take up to three months off from work without penalty, a component of the Family Leave Act, to help care for a newborn could "help bring them into the loop."

Convinced that the Doula program could also bring young fathers into that "loop," Doctor Gerstle wrote to Doula of North America online for more information and called Ms. Scruffie about the idea. "Oddly enough, she had just hired an intern to develop the program."

Enter Mike Pavlov. Pavlov, a master's degree student at Grand Valley State University through the NMC University Center, is an intern spearheading the Young Father Mentor Program, "part of a growing family of services becoming available for young first time fathers," said Ms. Crockett.

The program, now in the building stages, requires volunteer mentors to attend nine weeks of training and to commit to two to three hours per week for up to three years. Although mentors don't have to be fathers, they should "have some life experience, which provides greater insight," said Ms. Crockett.

Mr. Pavlov hopes to compete training and begin matching mentor with young fathers by



Roger Gerstle, MD, with his daughter Talia.

the beginning of 1997. Physicians can make significant contributions by "referring patients and making sure their staff is fully aware of the services offered for young fathers," said Ms. Crockett.

As the program takes-off, Ms. Crockett expects to apply for a funding grant to generate

an economic base. Currently, program funding comes from the Department of Community Health, as well as additional grants, donations and partial funding from the United Way.

The author is a Holt-based freelance writer.

"Just watching a male physician hold a newborn, or quickly change a diaper, can show dads that it is o.k. to be involved." -Roger Gerstle, MD

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Change an open invitation

Physicians can be architects of future healthcare

By Lee H. McCormick, MD

he American healthcare system seems to be in turmoil. Physicians are discouraged because they have seen significant erosion of both autonomy and income. Hospitals are downsizing, merging or closing. Insurance and managed care companies are growing in strength and profitability. Employers are demanding not only lower costs but accountability from those who provide care. The marketplace is attempting to determine the structure of healthcare in the 21st century, because Congress cannot. Is the outlook really as bad as it appears?

I don't think so. I believe that we are living in an exciting time, one that offers an unprecedented opportunity for physicians to influence the practice of medicine for decades to come. And I'm not alone. Leland Kaiser has written, "The future is only a threat to physicians attempting to resist change. Society is offering an open invitation to doctors to become the architects of our future health care system. There has never been a better time for imagination and creative challenge." Even such unexpected sources as Uwe Reinhardt and Paul Ellwood have predicted that physicians can "take back" the healthcare system. If those predictions are correct, what is it that we must do?

Strategies for the Future

Let me suggest to you three strategies for the 21st century, strategies that, I believe, will allow physicians to regain control of the healthcare system.

The first strategy is simple: Stop fighting change; control it. As individuals and as organizations, there is much that we can do.

The major changes in the healthcare system are due to the rapid growth of managed care, and it is this occurrence that is causing the most concern to physicians. A great deal of physician

time and effort is spent in futile and counterproductive efforts fighting managed care. I would submit to you that managed care is not inherently bad, any more than fee for service is inherently good. The determinants of whether a healthcare system is good or bad are very simple. A good system is one in which physicians control the medical decision-making, and can ensure that the right patient receives the right treatment by the right physician at the right time. Much of managed care is not

very good because this physician control is not present, but I believe that our efforts should be directed toward regaining that control, rather than opposing the system.

There is a major step that can be taken to resolve many of the concerns physicians have regarding managed care. That step is a mandate that all managed care plans have a mechanism through which physicians can provide input into plan policies without fear of retribution. This could best be done through the requirement of a medical staff structure in all managed care plans, a mechanism that has worked well in hospitals for decades. This could be accomplished rather easily if it were required in the accreditation standards of the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The second strategy for the 21st century is the development of physician organizations. It seems clear that the most successful way for physicians to practice in the future will be in close association with one another, either in formal groups or IPA's. That type of grouping will allow physicians to accept risk capitation, enter into virtual integration, and align incentives of primary care physicians and

specialists. It will allow them to regain clinical autonomy by assuming responsibility for their own utilization review, quality assurance and clinical outcomes measurement.

Remaining Solo Means Risks

Solo and small group practice has long been the traditional mode of practice, and it offered many advantages to both physician and patient. But whether we like it or not, it is no longer a viable practice style for many. A few will survive, but there will be difficulties and considerable risk. Those who choose to remain solo should do so because they are willing to take the risk, not because they deny that the risk exists. Solo practice will not provide the physician strength to regain control of the system.

In order for physicians to regain control, I am firmly convinced that we must be prepared to embrace not only capitation, but full risk capitation. Although it may be distasteful to those who staunchly support fee for service, capitation will likely be the major payment methodology in the foreseeable future. Physician groups that are able to assume risk will find that this offers several advantages. First, it will return clinical decision making and autonomy to the physicians; it will not be necessary to justify your actions to third parties if you are, in effect, spending your own money instead of theirs. When physicians are making the clinical decisions, we will be able to assure that our patients continue to receive high quality care. Second, it will create real incentives for physicians to examine their treatment protocols and outcomes, and work to develop low cost, high quality care. Third, it will require that we direct more attention to an area of medicine that we have often overlooked, namely keeping people well rather than treating them when they are sick. And, finally, as fee for service reimbursement continues to be reduced, at-risk capitation will present greater opportunity for profit.

Leaders Do What Is Right

What does that mean for physicians? First, it means that we must be leaders, for it has been said that the difference between managers and

leaders is that managers do things right but leaders do the right thing. But more importantly, I believe that the reaffirmation of integrity in our personal and professional lives will dispel the concerns others may have about returning control of the healthcare system to physicians.

Integrity in dealing with our patients means continuing to place their best interests first. It means providing the right care at all times, and neither withholding appropriate care for profit nor providing unnecessary care for profit. It means pricing our services fairly while continuing to care for those who cannot pay. It means remembering that our function is to serve our patients, and that prescriptions and procedures are not substitutes for compassion and caring. It means approaching our daily tasks with humility because we have been so honored as to be entrusted with the lives of others. It means communicating honestly with patients so that they may participate in their own care. It means that the death of a patient should not be considered a personal defeat, but a death with comfort and dignity should be considered a victory for the patient. It means, simply, doing the right thing.

I believe that we must also reaffirm integrity in our dealings with one another. The current healthcare system has cased great divisiveness between physicians. Integrity in our professional relationships means not seeking personal gain at the expense of our colleagues but seeking solutions that are mutually beneficial. It means not criticizing our colleagues simply because they disagree with us, but being willing to truly police ourselves by doing honest peer review. It means recognizing that we are not primary care physicians or specialists, or separated by any other artificial grouping; but that we are all privileged to be physicians. It means remembering that our enemy is disease and suffering, not each other. It means knowing that our patients will benefit most if we work together, and if our patients benefit we will too.

These remarks are excerpted from a presentation the author made on leaving office as chair of the AMA Organized Medical Staff Section June 21 in Chicago.

Newsmakers

John P. Papp, MD, a Grand Rapids internist, was elected to a threeyear term on the American Society of Internal Medicine Board of Trust-



ees. While splitting his time between general internal medicine and gastroenterology, Doctor Papp also serves as chair of the

Digestive Disease Institute at Blodgett Memorial Medical Center in Grand Rapids and is Michigan State University Department of Medicine clinical professor. He is also a past president of the American College of Gastroenterology and the Michigan Society of Internal Medicine, and current president of the Kent County Medical Society.

Robert E. Reid, MD, will be executive vice president and corporate medical director of William Beaumont Hospital System effective Jan. 2, 1997. The Royal Oak physician



currently serves as vice president and medical director of William Beaumont Hospital of Royal Oak. Doctor Reid served as Beaumont's vice

chief of obstetrics and gynecology for seven years before becoming associate medical director of Beaumont, Royal Oak in 1983 and additionally, vice president of staff development at Beaumont-affiliated St. Mary Hospital, Livonia, in 1993.

N.S. Rangarajan, MD, a Detroit OB/Gyn, has been promoted to executive vice president and chief operating officer of Health Care Services Administration. While leading medical and health care delivery throughout Health Care Services in Southeast Michigan, Doctor Rangarajan will continue as president and CEO of Comprehensive Health Services of Texas. He is a member of MSMS.

Jeffrey M. Devries, MD, MPH, is the Oakwood Healthcare System corporate director of Children's Health Services. The West Bloomfield physician has also worked extensively with children as the director of the Pediatric Residency Program and associate chair of the Department of Pediatrics at Henry Ford Health System. Doctor Devries serves on the national Board of Directors of the Ambulatory Pediatric Association and chairs its Education Committee. He has received the first-ever Ray E. Helfer Award for Innovation in Pediatric Education from the Ambulatory Pediatric Association, three Golden Bear Awards for Excellence in Resident Instruction from the Henry Ford Health Systems and the Senior Staff Award for Teaching Excellence in Medical Student Education from the University of Michigan Medical School.

Joseph C. Honet, MD, MS, FACP, Detroit, received the 1996 Frank H. Krusen Award for outstanding contributions to the field of physical medicine and rehabilitation (PM&R). Doctor Honet, who was chosen for the honor by the



American Academy of Physical Medicine & Rehabilitation, serves as department chair of PM&R at Sinai Hospital and is

on the hospital's board of directors. He has been an active player in the physical medicine field, having received the American Academy of Physical Medicine and Rehabilitation 1986 "Distinguished Clinician of the Year" award and serving as president of the American Academy of Physical Medicine and Rehabilitation, the American Association of Electromyography Electrodiagnosis, the Michigan Academy of Physical Medicine and Rehabilitation and the Northwest Association of Physical Medicine and Rehabilitation.

Anthony Femminineo, MD, received St. John Hospital-Macomb Center's Values award. Doctor Femminineo, who is actively involved in St. John's amputee clinic, was awarded for demonstrating values of service to community members, service and leadership, compassion, wisdom and stewardship to the

St. John Health System. The Detroit physician is a member of the AMA, MSMS, the Academy of Physical Medicine and Rehabilitation (PM&R) and the Michigan Academy of PM&R.

Obituaries

Adrian physician, Charles H. Heffron, MD, died July 22. He was 76. The family practitioner was an active community member, having been involved with the Elk's Club. the Moose Club, the Toledo Yacht Club and the Aerospace Medical Corporation. A University of Louisville Medical School graduate, he did post-graduate work at the University of Minnesota's flight surgeon school and was later a member of the Civil Air Patrol. He was also a member of the AMA and MSMS.

A West Michigan pioneer in laparoscopic and laser surgery, James C. Heersink, MD, Kalanazoo, died September 10. He was 49. The surgeon was the first area physician to perform a laparoscopic gall bladder removal in Kalamazoo in April 1990. A University of Colorado Medical School graduate, Dr. Heersink was an advocate of using computers in medicine and introduced advanced nutritional support for surgical patients. Before joining Surgical Associates of Kalamazoo in 1981, Dr. Heersink was in private practice for four years. Dr. Heersink was actively involved with the Grace Christian

Reformed Church as an elder and was a member of the American College of Emergency Physicians, American College of Surgeons Candidate Group and MSMS.

A former chief of staff at Mercy Memorial Hospital, Dale W. Douglas, MD, Monroe, died August 21. He was 78. While at Mercy, Dr. Douglas, a general surgeon, also chaired the surgery department at Mercy and Memorial Hospitals. Even in retirement, Dr. Douglas continued working part-time as a physician for Mercy Memorial's Corporate Connection and at Ford Motor Company's Monroe Stamping Plant. Dr. Douglas graduated from the University of Illinois School of Medicine in 1944 and completed his internship at Marine Hospital, Norfolk, Va., where he spent two years as a captain in the Army Medical Corps before being discharged in 1946. Dr. Douglas served on the board and was a past president of the Michigan Cancer Foundation and was a past chair of the professional division of the United Way of Monroe County Inc. He was a Fellow of the American College of Surgeons, the American Board of Surgeons and a member of the American Medical Association, MSMS and the Monroe County Medical Soci-

Orthopedic surgeon Victor S. Mateskon, MD, Petoskey, died August 31. He was 80. The St. Louis University School of Medicine graduate served from 1943 to 1946 in the Army Medical Corps before joining the staff at Little Traverse Hospital in Petoskey. He was a past president of the Northern Michigan Medical Society, a member of MSMS, the Michigan Orthopedic Society, the American College of Surgeons, the American Academy of Orthopedic Surgeons and the Clinical Orthopedic Society.

Joseph J. Reichman, MD, Saginaw, an internist specializing in chronic disease and rehabilitation, died September 3. He was 86. Dr. Reichman was president-elect of Macomb County Medical Society before relocating with Saginaw County Hospital, where he served as medical director of chronic disease and rehabilitation. The Georgetown University Medical School graduate was a member of MSMS and the Saginaw County Medical Society.

New Members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Debra S. Achinger, MD, Royal Oak Ashrof M. Ads. MD. Kalamazoo Robert Alexander, MD, Detroit Mark R. Anderson, MD, Fenton Michael Aulicino, MD, Detroit Nicholas C. Bakris, MD, Troy Mark L. Bernstein, MD, Ypsilanti William K. Bradfield, MD, Howell Richard M. Carr, MD, Dearborn Jean B. Cederna, MD, Ypsilanti John R. DeQuardo, MD, Ann Arbor Kim Eagle, MD, Ann Arbor Prine J. Eubanks, MD, Southfield Gregory P. Gilmet, MD, Southfield Amitabh Goel, MD, Norway Douglas H. Green, MD, Battle Creek

William H. Herman, MD, Ann Arbor Aref I. Hindawi, MD, Clinton Twp. Timothy Hodge, DO, Lansing Sylvia K. Hollowell, MD, Detroit Mark Justus, MD, Livonia Scott B. Karlene, MD, Flint Ramesh C. Kilaru, MD, New Haven Jong Ku Kim, MD, Battle Creek Roger Klein, MD, West Bloomfield William H. Kole, MD, Dearborn Seth W. Malin, MD, Kalamazoo

Pamela A. Marcovitz, MD, Ann Arbor

O.L. Matthews, MD, Detroit Karen W. Merritt, MD, Grosse Pointe

Carleen M. Messina, DO, Flint Irene C. Metro, MD, Farmington Hills

Stephanie E. Meyers, MD, Ypsilanti Bruce D. Misare, MD, Ypsilanti Bruce K. Muma, MD, Sterling Heights

Teresa M. Myers, MD, Battle Creek Patricia C. Nester, MD, Canton Michelle D. Rossmann, MD, Farmington Hills

John E. Samani, MD, Ypsilanti Muhammed A. Sankari, MD, Caro Troy A. Sargent, MD, Monroe Victoria C. Serbia, MD, Ann Arbor Yash P. Sethi, MD, Madison Heights, Ibrahim S. Shamieh, MD, Standish Anjum Shariff, MD, Southfield Amarnath Sortur, MD, Detroit Sendhil Subramanian, MD, Southfield

Christopher E. Swanson, MD, Royal Oak

Andrew Tartaglione, DO, Dearborn Robert Vartabedian, MD, Plymouth Xiaohong Wang, MD, Detroit Catherine L. Ward, DO, Ann Arbor Ira S. Wolke, MD, Dearborn

MSMS Members Keeping Active

The Michigan State Medical Society would like to recognize the following members who sit on the Boards of associations around the state:

National Multiple Sclerosis Society, Michigan Chapter, Inc. Stanton Elias, MD, Wayne County Ronald Taylor, MD, Oakland County

American Lung Association of Michigan

Thomas A. Abraham, MD, Kalamazoo County

Raymond Demers, MD, Wayne County

John Popovich, MD, Wayne County K.P. Ravikrishnan, MD, Oakland County

American Cancer Society - Michigan Division, Inc.

Arthur T. Porter, MD, President - Wayne County

Mary Elizabeth Roth, MD, Vice President - Oakland County

Nikolay V. Dimitrov, MD, National Division Director - Ingham County

Dorit D. Adler, MD, Director-at-Large - Washtenaw County

Aaron P. Scholnik, MD, Directorat-Large - Marquette - Alger County

Michigan Health and Hospital Association, Corporate Board

Edwin H. Gullekson, MD, FAAFP-Genesee County

Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Amiya Samanta, MD, 7430 Second Ave., #610, Detroit, MI, 48202

Action, Date Taken: Reprimand, Fine-\$1,000.00, 9-20-96

Reason: Unethical Business Practice

Name: Eddie M. Sorano, MD, 2600 Martin Luther King, Ste. 420, Detroit, MI 48208

Action, Date Taken: Reprimand, Fine-\$1,000.00, 9-20-96

Reason: Unethical Business Practice

Name: Eric J. Robb, MD, 1001 Kearney, PO Box 611003, Port Huron, MI, 48061

Action, Date Taken: Reprimand, Fine-\$1,000.00, 8-28-96

Reason: Failure to meet Continuing Education Requirements

Name: Robert G. Glinski, DO, 29521 Ford Rd, Garden City, MI 48135

Action, Date Taken: License Suspended-6 mo. & 1 day, Fine-\$10,000.00, 10-5-96

Reason: Negligence/Incompetence

Name: Clarence W. Wilson, DO, 2776 Flushing Road, PO Box 1116, Flint, MI 48501

Action, Date Taken: License Revoked, Fine-\$20,000.00, Summary Suspension Dissolved

Reason: Drug Diversion

Name: David W. G. Defoe, MD, 20755 Greenfield, Southfield, MI 48075

Action, Date Taken: License Suspended - 1 yr., 10-18-96

Reason: Substance Abuse

Name: James Sirajuddin, MD, 203 Center St., South Haven, MI 49090

Action, Date Taken: Reinstate w/Limited License-3 yrs., Probation-3 yrs. Concurrent w/limitations, 9-17-96

Name: Bernard A. Sage, MD, 210 Woodcrest Dr., Dearborn, MI 48124

Action, Date Taken: License Permanently Surrendered, 10-18-96

Reason: Failure to meet continuing education requirements

Name: Arvind S. Patel, MD, 2141 E. Jefferson, Detroit, MI 48207

Action, Date Taken: Probation-1 yr., Fine-\$1,000.00, 9-18-96

Reason: Violation of General Duty/Negligence

Name: Ronald P. D'Agostino, DO, Box 504, RR 1, 1504 Sand Point Rd., Munising, MI 49862

Action, Date Taken: License Summarily Suspended, 10-5-96

Reason: Mental/Physical Inability to Practice

Name: Robert G. Glinski, DO, 29521 Ford Rd., Garden City, MI 48135

Action, Date Taken: The Final Order dated 9-5-96 is Stayed, 9-5-96

Name: Muhammad M. Butt, MD, 224 Circle Dr., Traverse City, MI 49684

Action, Date Taken: Reprimand, 9-18-96

Reason: Violation of General Duty/Negligence

Grant Creates Greater Online Access to Immunization Information

Through a federal grant of \$650,000 southeast Michigan physicians will have greater on-line access to childhood immunization information. The grant will be matched by the Michigan Department of Community Health (MDCH) and the total \$1.3 million will be used towards a high-tech computer network which will link public and private providers in southeast Michigan for greater online access to childhood immunization information. The network, using standardized computer messaging protocols to share immunization information with physicians, should help alleviate communication problems which contribute to Michigan's low immunization rate.

Slain Physician's Colleagues **Establish Center**

Medical colleagues of Deborah Iverson, MD, the former clinical director of the Beaumont Eye Institute who was slain in May, are establishing the Deborah Iverson Ophthalmic Learning Center at Beaumont Hospital. The center, a stateof-the-art library, reflects Doctor Iverson's dedication to teaching and education.

Communities Linked to Internet Health Information

By early 1997, Michigan residents looking to kick their smoking habit will be able to learn how by walking to a computer. The University of Michigan Comprehensive Center will carry out a \$1 million project approved by Gov. John Engler which will link communities with current

health information on the Internet. The first-of-its-kind statewide network will deploy between 50 and 100 computer kiosks, similar to automated teller machines, in Michigan communities. Michigan residents can access the interactive homepage, developed and updated by U of M experts, at libraries, work sites, health clinics, shopping malls and other public places. Once on line, readers can obtain information on health topics such as cancer screening, children's immunization and changing diets. For more information about the Michigan Interactive Health Kiosk program, please contact the U of M Health System at (800) 742-2300, ext. 7855.

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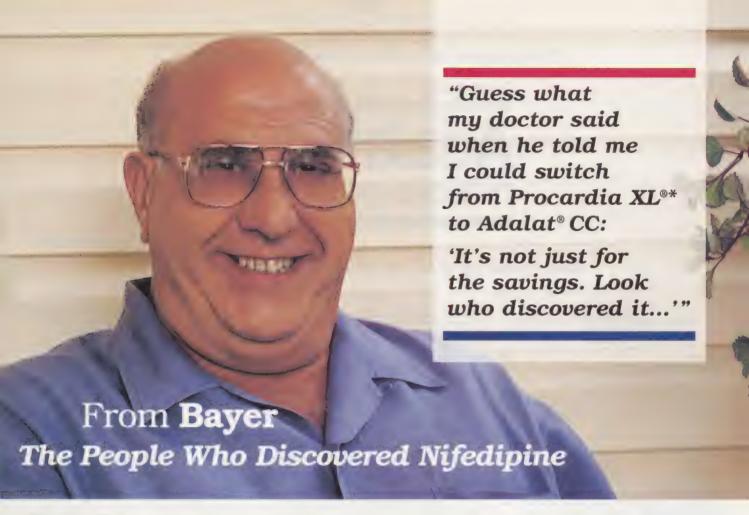
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^{*}Procardia XL (nifedipine) is a registered trademark of Pfizer Labs Division, Pfizer Inc.

[†]Calculations based on suggested Average Wholesale Price (AWP).⁵ AWP is from a published price list and may or may not represent the actual price to pharmacists or consumers.

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INDICATION AND USAGE: ADALAT CC is indicated for the treatment of hypertension. It may be used alone or in combination with other antihypertensive agents.

CONTRAINDICATIONS: Known hypersensitivity to mifedipine.

WARNINGS: Excessive "Hypotensien: Although in most patients the hypotensive effect of nifedipine is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial infrarion or at the time of subsequent upward dosage adjustment, and may be more likely in patients using concomitant beta-blockers.

likely in patients using concomitant belra-blockers. Severe hypotension and/or increased fluid volume requirements have been reported in patients who received immediate release capsules together with a beta-blocking agent and who underwent coronary artery bypass surgery using high dose fentaryl anosthesia. The interaction with high dose fentancy appears to be due to the combination of nifedipine and a beta-blocker, but the possibility that it may accur with nifedipine alone with low doses of fentancy in other surgical procedures, or with other narcoic analyses cannot be ruled out. In nifedipine-treated patients where surgery using high dose fentancy are continued to the physician should be aware of these potential problems and, if the patient's condition permits, sufficient lime (at least 36 hours) should be allowed for nifedipine to be weshed out of the body prior to surgery.

snown we moves or intemptine to be wished out of the body prior to surgery.

Increased Angine and/or Myocardial Infarction: Rarely, potients, porticularly those who have severe obstructive coronary artery disease, have developed well documented increased frequency, duration and/or severity of angina or acute myocardial infarction upon starting nifedipine or at the time of dosage increase. The mechanism of this effect is not established.

Beta-Blocker Withdrawal: When discontinuing a beta-blocker it is important to taper its dose, if possible, rather than stopping abruptly before beginning nifedipine. Patients recently withdrawn from beta blockers may develop a withdrawal syndraw with increased angina, probably related to increased sensitivity to caterholamines. Initiation of nifedipine treatment will not prevent this occurrence and on occasion has been reported to increase it.

Congestive Heart Failure: Arrely, potents (usually while receiving a beta-blocker) have developed heart failure after beginning nifedipine. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of infedipine would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

flow across the aartic valve.

PRECAUTIONS: General - Hypotension: Because nifedipine decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and
titration of ADAIAT (C is suggested. Close observation is especially recommended for patients
already taking medications that are known to lower blood pressure (See WARNINGS).

Peripheral Edema: Mild to moderate peripheral edema occurs in a dose-dependent
manner with ADAIAT (C. The placebo subtracted rate is approximately 8% at 30 mg, 12%
at 60 mg and 19% at 90 mg daily. This edema is a localized phenomenan, thought to be
associated with vasadiation of dependent arterioles and small blood vessels and not due
to left ventricular dysfunction or generalized fluid retention. With patients whose hypertension is complicated by congestive heart failure, care should be taken to differentiate
this peripheral edema from the effects of increasing left ventricular dysfunction. Harformation for Partients; ADAIAT (C is on extended release tablet and should be
swallowed whole and taken on an empty stomach. It should not be administered with
food. Do not chew, divide or crush tablets.

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of

tood. Do not chew, divide or crush tablets.

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted. The relationship to nifedipine therapy is uncertain in most cases, but probable in some. These laboratory orbinomalities have rarely been associated with clinical symptoms; however, cholestasis with or without joundice has been reported. A small increase (<5%) in mean alkaline phosphatase was noted in patients treated with ADALAT CC. This was an isolated finding and it rarely resulted in values which fell outside the normal range. Rare instances of allergic hepatitis have been reported with nifedipine treatment. In controlled studies, ADALAT CC did not adversely affect serum uric acid, glucose, cholesterol or potassium. Wifediatine, like other calcium channel blackers, decreases platelet appreciation in visito.

ADALAI LC did not adversely affect serum unic acid, glucose, cholesterol or potassum. Nifedigine, like other calcium channel blockers, decreases platelet aggregation in vitro. Limited clinical studies have demonstrated a moderate but statistically significant decrease in platelet aggregation and increase in bleeding time in some infedigine patients. This is thought to be a function of inhibition of calcium transport across the platelet membrane. No clinical significance for these findings has been demonstrated. Positive direct Coombs' test with or without hemolytic anemia has been reported but a causal relationship between infedigine administration and positivity of this laboratory test, including hemolysis, could not be determined.

test, inclouding interrupts, count not we determined.

Although rifledighine has been used safely in patients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, care reversible elevations in BUN and serum creatinish have been reported in patients with pre-existing fromic renal insufficiency. The relationship to nifedipine therapy is uncertain in most cases but probable in some. Drug Interactions: Beta-adrenergic blocking agents: (See WARNINGS).

ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placeba-controlled clinical trial. However, there have been accasional literature reports suggesting that the combination of indeligine and beta-adrenergic blocking drugs may increase the likelihood of congestive heart failure, severe hypotension, or exacerbation of angina in patients with cardiovascular disease. severe ryguenesson, or exceedantion or angined in patients with elevated disposition levels, or bigligibles. Since there have been isolated reports of patients with elevated disposit levels, and there is a possible interaction between disposit and ADALAT CC, it is recommended that disposit levels be monitored when initiating, adjusting, and discontinuing ADALAT CC to avoid possible over- or under-digitalization.

to avoid possible over- a unaer-aginaization.

Cournaria Anticoagulants: There have been rare reports of increased prothrombin time in patients taking coumarin anticoagulants to whom nifedipine was administered. However, the relationship to nifedipine therapy is uncertain.

Quinidine: There have been rare reports of an interaction between quinidine and nifedipine (with a decreased plasma level of quinidine).

The digital anomalies seen in infedipine-exposed rabbit puts are strikingly similar to those seen in puts exposed to phenytoin, and these are in turn similar to the phenomenate of the

with in there exposure to phenytoin. There are no deequate and well-controlled studies in pregnant women. ADALAT CC should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Nursing Mothers: Middipine is excreted in human milk. Therefore, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

ADVERSE EXPERIENCES: The incidence of adverse events during treatment with ADALAT CC in doses up to 90 mg daily were derived from multi-center placebo-controlled clinical trials in 370 hypertensive potients. Atenolol 50 mg once daily was used concomitantly in 187 of the 370 patients on ADALAT CC and in 64 of the 126 patients on placebo. All adverse events reported during ADALAT CC therapy were tabulated independently of their causal relationship to medication.

their cousal relationship to medication.

The most common adverse event reported with ADALAT® (C was peripheral edema. This was dose related and the frequency was 18% on ADALAT (C 30 mg daily, 22% on ADALAT (C 60 mg daily and 29% on ADALAT (C 90 mg daily versus 10% on placebo. Other common odverse events reported in the above placebo-controlled trials include: Headache (19%, versus 13% placebo incidence); Flushing/heat sensation (4%, versus 0% placebo incidence); Disziness (4%, versus 2% placebo incidence); Flushing/heat sensation (4%, versus (4%, versus 4% placebo incidence); Musica (2%, versus 1% placebo incidence); Constipation (1%, versus 0% placebo incidence).

Where the frequency of adverse events with ADALAT CC and placebo is similar, causal relationship cannot be established.

The following adverse events were reported with an incidence of 3% or less in daily doses up to 90 mg:

Body as a Whole/Systemic: chest pain, leg pain Central Nervous System: paresthesia, vertigo Dermatologic: rash Gastrointestinal: constipution Musculeskeletal: leg cramps Respiratory: epistaxis, rhinitis Urogenital: impotence, urinary frequency

Other adverse events reported with an incidence of less than 1.0% were:

Other odverse events raported with an incidence of less than 1.0% were:

Body as a Whole / Systemic: cellulitis, chills, facial edema, neck pain, pelvic pain,
pain Cardievascular: atrial fibrillation, bradycardia, cardiac arrest, extrasystole,
hypotension, polipitations, phlebitis, postural hypotension, tachycardia, cutaneous and
iectases Central Nerveus Systeme anxiety, confusion, decreased libid, depression,
hypertonia, insomnia, somnolence Dermatolegic: pruritus, sweating
Gastrointestiael: abdominal pain, diarrhea, dy mount, dyspepsia, esophogitis, flatulance, gastrointestinal hemorrhage, vomiting Hematolegic: lymphadenopathy
Metabelic: gout, weight loss Musculoskeletal: arthrafqia, arthriis, myalgia
Respiratery: dyspnea, increased cough, rales, pharyngitis Special Senses: abnormal vision, amblyopia, conjunctivitis, diplopia, tinnibus Uragenital/Reproductive:
kidney cakulus, nocturio, breast engargement

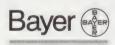
The following adverse events have been reported rarely in patients given nifedipine in other formulations: allergenic hepatitis, olopecia, anemia, arthritis with ARA (+), depression, erythromelalgia, extolictive dermafitis, tever, gingival hyperplasia, gynacomastia, leukapenia, mood changes, muscle cramps, nervousness, paranoid syndrome, purpura, shakiness, sleep disturbances, syncope, taste perversion, thrombocytopenia, transient blindness at the peak plasma level, tremor and urricaria.

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References: 1. IMS NPA+, January 1996. 2. Glasser SP, Ripa SR, Allenby KS, Schwartz LA, Commins BM, Jungerwirth S, on behalf of the Nifedipine Study Group. The Efficacy and Safety of Once-Daily Nifedipine Administered without Food: The Coat-Core Formulation Compared with the Gastrointestinal Therapeutic System Formulation in Patients with Mild-to-Moderate Hypertension. Clin Ther. 1995;17(2):296-312. 3. Glasser SP, Jain A, Allenby KS, Shannon T, Pride K, Pettis PP, Schwartz L, MacCarthy EP, and the Nifedipine Study Group. The Efficacy and Safety of Once-Daily Nifedipine: The Coat-Core Formulation Compared with the Gastrointestinal Therapeutic System Formulation in Patients with Mild-to-Moderate Diastolic Hypertension. Clin Ther. 1995;17(1):12-29.

4. Adalat CC Product Monograph, April 1995.

5. Redbook Update. Montvale, NJ, Medical Economics Data, Inc., June 1996.



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MSMS Meetings

January

15, MSMS Board of Directors Meeting. Location: MSMS Head-quarters, East Lansing. Contact: Irene Frost at MSMS at (517) 336-5734.

February

28-March 1, MSMS Joint Section Meeting. Location: Ritz Carlton Hotel, Dearborn. Contact: Judy Marr at MSMS at (517)336-5747.

March

3, 1997 MSMS Maternal Health Conference. Location: Dearborn Inn, Dearborn. Contact: Sarah Cressman at MSMS at (517) 336-5727.

5, MSMS Board of Directors Meeting. Location: MSMS Headquarters, East Lansing. Contact: Irene Frost at MSMS at (517)336-5734.

May

2-4, 1997 MSMS House of Delegates. Location: Grand Traverse Resort, Traverse City. Contact: Donna Brown at MSMS at (517)336-5735.

19, Health Education Foundation Golf Outing. Location: Lansing Country Club. Contact: Judy Marr at MSMS at (517) 336-5744.

AMA Meetings

January

8-11, 1997 AMA State Legislation Meeting. Location: Palm Desert, CA. Contact: Greg Aronin at MSMS at (517) 336-5739.

March

16-19, AMA 1997 Leadership Conference. Location: Marriott Hotel, Philadelphia, PA. Contact: Kevin A. Kelly at MSMS at (517) 336-5743.

June

22-26, AMA Annual Meeting. Location: Hyatt Regency, Chicago, IL. Contact: Judy Marr at MSMS at (517) 336-5744.

Michigan Specialty Society Meetings

January 1997

31-Feb. 2, Michigan Society of Medical Assistants Midwinter Seminar. Location: McCamly Plaza Hotel, Battle Creek. Contact: Sue Storey, CMA-C, 2336 Ramblewood Dr., Kalamazoo, MI 49009.

February 1997

14-16, AAMA Board of Trustees Meeting. Location: Chicago. Contact: Caroline Kimmel at MSMS at (517) 337-7587. ■

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EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I CME credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. In the listing below, of programs that carry at least three hours of Category I credit, a contact is indicated so the physician can obtain additional information. Other educational opportunities of interest to physicians are also listed.

December

17, 24, Bar-Levav Educational Association Ongoing Seminar Series "Extratherapeutic contacts in group psychotherapy: Risks and Benefits." Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center Suite 1275, Southfield, MI 48075 (810) 353-5333. Approved for: 4 Category 1 credits. No registration fee required.

January

4-8, Addiction Psychiatry, Medicine and Psychology Exam Review and Update Course. Location: Phoenix. Contact: Joseph Selliken, MD, 1094 East Dawn Dr., PO Box 2218, Terre haute, IN 47802; Phone (800) 356-7537 or (812) 299-5658 or Fax (812) 299-2775. Registration fee: \$840 for practicing physician; \$560 for resident, fellow, or non-physician. Approved for: Hours vary.

21-23, Breast Cancer Screening in Women Ages 40-49. Location: Natcher Conference Center, The William H. Natcher Building, National Institutes of Health, Bethesda, MD. Contact: Conference Registrar Technical Resources Internaitonal, Inc., 3202 Tower Oakds Boulevard, Rockville, MD, 20852; Phone (301) 770-0610, Fax (301) 468-2245, Email: confdept@tech-res.com, WWW: http:\\text.nom.nih.gov\nih\nih.html or ftp:\\pulic.nom.nih.gov\nih\nih.html or registration fee. Ap-

proved for: 15 Category 1 CME credits.

24-26, Clinical Nuclear Cardiology: Case Review with the Experts. Location: Decars-Sinai Medical Center, Los Angeles, CA. Contact: American College of Cardiology, PO Box 79231, Baltimore, MD, 21279-0231, Phone 1-800-253-4636. Approved for: 18.5 Category 1 credits. Registration fee: ACCmember - \$500 by Jan. 10; Nonmembers - \$575 by Jan. 10. Registration after Jan. 10 will be on-site only and \$50 more.

February

11-13, Interventions to Prevent HIV Risk Behaviors. Location: Natcher Conference Center, The William H. Natcher Building, National Institutes of Health, Bethesda, MD. Contact: Conference Registrar Technical Resources International, Inc., 3202 Tower Oakds Boulevard, Rockville, MD, 20852; Phone (301) 770-0610, Fax (301) 468-2245, Email: confdept@tech-res.com, WWW: http:\\text.nom.nih.gov\ nih\nih.html or ftp:\\pulic.nom.nih .gov\hstap No registration fee. Approved for: 14 Category 1 CME credits.

17-20, State-of-the-Art Echocardiography. Location: Shertaon El Conquistador, Tucson, AZ. Contact: American College of Cardiology, Attn: EP, PO Box 79231, Baltimore, MD, 21279-0231, Phone

1-800-253-4636. Approved for: 25 Category 1 credits. Registration fee: ACC members - \$550 by Feb. 3; Non-members \$600 by Feb. 3. Registration is on-site only after Feb. 7 and \$50 more.

23-27, Intensive Drug Development and Regulation Course. Sponsored by: Tufts University Center for the Study of Drug Development and the American Society for Clinical Pharmacology and Therapeutics. Location: Ritz-Carlton Hotel, Boston, MA. Contact: Toni Snow at (617) 636-0187. Approved for: 26 Category 1 credits. Registration fee: \$1500, including a \$100 non-refundable deposit.

March

3-6, 13th Annual Cardiovascular Conference at Lake Louise. Location: Lake Louise, Alberta, Canada. Contact: American College of Cardiology, Attn: EP, PO Box 79231, Baltimore, MD, 21279-0231, Phone 1-800-253-4636. Approved for: 17.5 Category 1 credits. Registration fee: ACC members - \$450 by Feb. 17; Non-members \$545 by Feb. 17. Registration is on-site only after Feb. 17 and \$50 more.

3-7, Cardiology at Cancun 1997. Location: The Westin Regina Cancun, Cancun, Mexico. Contact: American College of Cardiology, Attn: EP, PO Box 79231, Baltimore, MD, 21279-0231, Phone 1-800-253-4636. Approved for: 26.5 Category

EDUCATIONAL OPPORTUNITIES

1 credits. Registration fee: ACC members - \$570 by Feb. 17; Nonmembers \$675 by Feb. 17. Registration is on-site only after Feb. 17 and \$50 more.

14-16, Neurology for the Non-Neurologist. Location: Doubletree Hotel, Palm Springs, CA. Contact: Medical Education Resources, 1500 W Canal Court, Suite 500, Littleton, CO 80120-4569; Phone 1-800-421-3756, Fax 303-798-5731. Approved for: 11 Category 1 credits. Registration fee: \$375.

21-22, Integrated Care of the Thoracic Surgery Patient: A Seminar for Allied Health Professionals. Location: Washington University Medical Center, Eric P. Newman Education Center (EPNEC), St. Louis, MO. Contact: Office of Continuing Medical Education, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093; Phone: (314) 362-6891 in MO or (800) 325-9862 Interstate or Fax (314) 362-1087. Approved for: Hour-for-hour basis. Registration fee: \$200.

24-26, Management of Hepatites C. Location: Natcher Conference Center, The William H. Natcher Building, National Institutes of Health, Bethesda, MD. Contact: Conference Registrar Technical Resources Internaitonal, Inc., 3202 Tower Oakds Boulevard,

Rockville, MD, 20852; Phone (301) 770-0610, Fax (301) 468-2245, Email: confdept@tech-res.com, WWW: http:\\text.nom.nih.gov\ nih\nih.html or ftp:\\pulic.nom.nih .gov\hstap No registration fee. Approved for: 14 Category 1 CME credits.

April

3-4, Challenges and Changes in Obstetrics and Gynecology. Location: Towsley Center, Ann Arbor, MI. Contact: Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, Unversity of Michigan Medical School, PO Box 1157, Ann Arbor, MI 48106-1157.

3-5, Interpretation and Treatment of Cardiac Arrhythmias. Location: Buena Vista Palace, Walt Disney World Resort, Lake Buena Vista, FL. Contact: American College of Cardiology, PO Box 79231, Baltimore, MD, 21279-0231, Phone 1-800-253-4636. Approved for: 23.5 Category 1 credits. Registration fee: ACC members - \$460 by Mar. 20; Non-members - \$535 by Mar. 20. Registration after Mar. 20 will be on-site only and \$50 more.

3-6, The Osler Institute Addiction Psychiatry, Medicine and Psychology Exam Review and Update Course. Location: Phoenix. Contact: Joseph Selliken, MD, 1094 East Dawn Dr., PO Box 2218, Terre haute, IN 47802; Phone (800) 356-7537 or (812) 299-5658 or Fax (812) 299-2775. Registration fee: \$840 for practicing physician; \$560 for resident, fellow, or non-physician. Approved for: Credits vary.

Ongoing

Case Studies in Environmental Medicine, Location: Your office/ home (self-instructional monographs). Sponsor: The Agency for Toxic Substances and Disease Registry, Division of Health Education. Contact: Michele Borgialli, Michigan Department of Public Health, Division of Health Risk Assessment, PO Box 30195, Lansing, MI 48909, (517)335-9647. Approved for: Up to 33 hours of free Category 1 Credits; 1 per case study.

1996 MSMS Survey on Practice Characteristics

Information is power, and, in the closing decade of this century, data has become the tool that helps us succeed where others have failed.

MSMS is conducting the third Survey on Practice Characteristics this fall. This effort builds on the assessment of medical practice in Michigan that first began in 1992, when your House of Delegates called for more statistical information on Michigan physicians.

This year we have updated the questions on managed care and technology, while leaving intact the demographic and environment questions that allow us to follow trends over time.

The data from the previous surveys in 1992 and 1994 have been used in a variety of ways, including:

- presentations to county medical society, specialty society and hospital medical staff meetings to inform member physicians.
- discussions with legislators and state policymakers.
- advocacy efforts with health insurance companies and managed care plans.
- educational campaigns for the public.
- background information for individual physicians as they interact with interested parties in their local communities.

If you are an actively practicing physician and a member of MSMS, you should have received a copy of the survey in the mail in early November. Please take the time to complete the survey and return it to MSMS as soon as possible. Your response is very important to us, and all individual data will be held strictly confidential.

Thank you for your assistance in this important project.

stichigen State Heited Society

ASHS SIRVEY

Comprehensive results of the survey will be available to you in the May issue of *Michigan Medicine*. If you have any questions about the survey, please call Julie Lester, Chief of Health Care Research, at (517) 336-5768, or you can e-mail her at jlester@msms.org.

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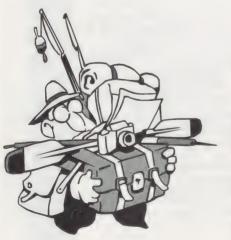
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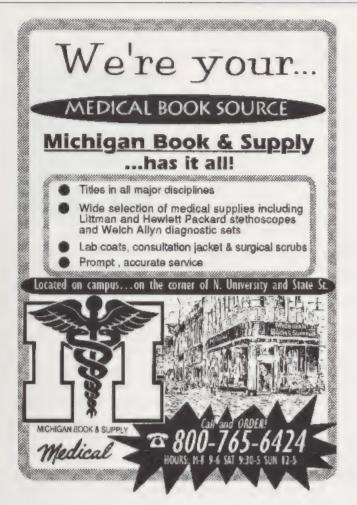


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Are We Up To It?

Managed Care A Tough Job

By. W. Peter McCabe, MD

Third party payers have always accorded cosmetic surgery the disdain one might reserve for pemphigus or body odor. Not exactly criminal or immoral, but barely tolerable and certainly non-reimbursable.

Which is surprising, since no less an authority than Princeton economist Uwe Reinhardt has call cosmetic surgery the one true economic model in health care. After all, there is no third party to obfuscate the deal, it's just between doctor and patient. Call most plastic surgeons' offices and they'll quote their standard fees over the phone. No up coding or down coding, no bundling or unbundling. You can shop fees, and if you're a deft negotiator, you might even get the quote lowered. And the fee is guaranteed whether the operation takes two hours or four, or whether 10 suture packs or 100 are used.

And most of all, you, the prospective patient, are paying for it out of your own pocket, a fact that gives you an intimate sense of involvement in the management of your own affairs that only imminent penury can give you.

So it comes as somewhat of a surprise that even these last stalwarts of the medical free market, the plastic surgeons, have finally faced up to managed care. If *they're* embracing it, baby, it's here. Not only that, but they're generating some pretty good insights into future trends.

For one thing, instead of just shedding crocodile tears over the physician surplus, they're starting to voluntarily cut residency positions, realizing that it's unproductive to train surgeons for jobs that may not be there. Some of this is driven by recent surveys that show an alarmingly high percentage of recent training graduates cannot find jobs, putting plastic surgeons up there with anesthesiologists in terms of the professional bread line.

All this underscores the fact that there is a lot of slack out there in the cold, cruel world. I have often questioned whether underutilization of physician manpower hasn't been a nasty little secret of our profession... many doctors not having enough meaningful work to fill their available time. In the new era of cost efficient medicine, there will be a tendency to use physicians more productively. While many might applaud this better utilization, it will make the job market tighter, particularly when the more mundane, but time consuming, tasks are assigned to what are euphemistically called "physician extenders." Doctors on the cheap. What do they call a cardiologist in California? Waiter.

Many of our colleagues call for a new hybrid, the doctor/manager, as the answer to our profession staying in the driver's seat. I'm all for that, but in this new day, the emphasis will be on the "manager" part of the equation, with the primary challenge being to wring as much efficiency as possible out of the delivery system. It's a tough job requiring tough de-



cisions and tough actions... from a member of a profession much more used to kindness than to a form of business, toughness that can border on the brutal. I question whether we're up to it, or even whether we should be in that arena.

But the landscape is littered with the detritus of those who didn't adjust to new realities. Despite all the technological innovation and therapeutic advances of the modern era. in certain ways we're delivering care the same way we did 100 years ago. Some might say we're the world's oldest cottage industry. I suppose a certain timelessness is inevitable when the one-on-one doctor/patient is paramount. But some of our business practices are better suited to the era of high button shoes. Look at the typical hospital bill, itemizing every little aspirin as if an army of Uriah Heeps in green eyeshades is working overtime. It's frequently a fiction anyway, but it betrays a mindset better suited to the country store. Or stocking every surgeon's favorite supplies, catering to every whim and idiosyncrasy.

Actually, it sounds good to me... but I, like many others, will have to be dragged kicking and screaming into the 20th century. Who's going to do it— my peers, or "headquarters?"

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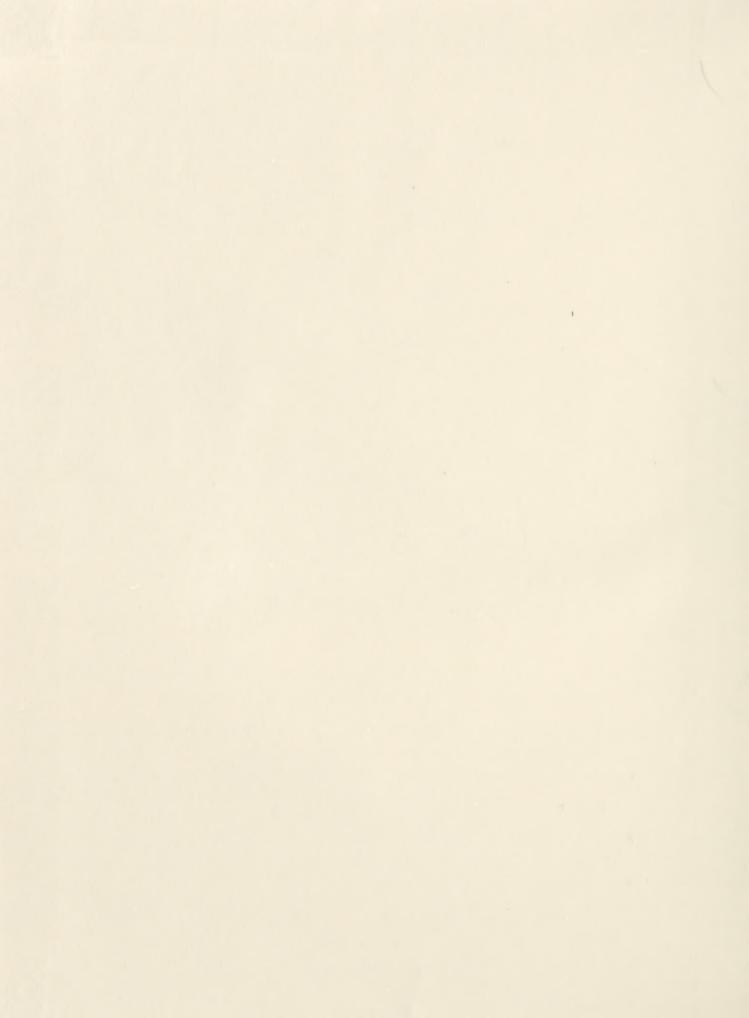
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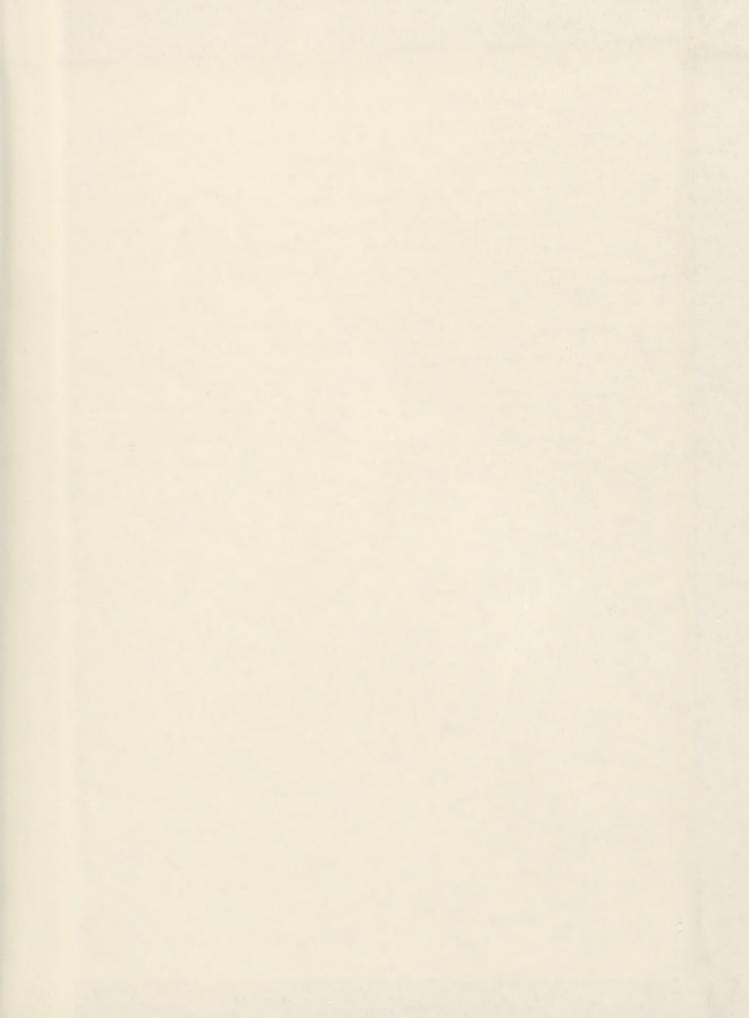
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